

FILED APR 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9580

2979

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Illinois b. COUNTY Williamsboro			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Marion		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL (If not in hospital or institution, give street address or location)				e. STREET ADDRESS (If rural, give location) Rural			
3. NAME OF DECEASED (Type or Print) a. (First) MORRIS			b. (Middle) LEE		c. (Last) FORD		4. DATE OF DEATH (Month) (Day) (Year) April 1, 1955
5. SEX <input type="radio"/> Male <input type="radio"/> Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH May 22, 1931		9. AGE (In years last birthday) 23	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Const.		11. BIRTHPLACE (City and State or Foreign Country) Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Harve Ford		13b. MOTHER'S MAIDEN NAME Esther Webb		14. NAME OF HUSBAND OR WIFE Never Married			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Esther Ford Chebanse, Ill.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus					Min.
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease					5 yrs.
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 3-16- , 19 55 , to 4-1- , 19 55 , that I last saw the deceased alive on 4-1- , 19 55 , and that death occurred at 5:30 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. D. Vernillion M.D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 4-1-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-2-55	24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		24d. LOCATION (City, town, or county) (State) Marion, Ill.		
DATE REC'D BY LOCAL REG. APR 2 1955		REGISTRAR'S SIGNATURE Carl Smith - MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 "ashington.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. W. Burley*.....
Licensed Embalmer No. *3653*.....
P. O. Address *H. Lantz*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.