

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'59 0 4 3 4 7 4

FILED VS JAN 11 1960

Registration District No. 43

Primary Registration District No. 2007

STATE FILE NUMBER 843
Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CARTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>POPLAR BLUFF</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FREMONT</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>POPLAR BLUFF HOSP</u>		Length of stay in lb <u>6 HRS</u>	d. STREET ADDRESS (If outside, give location) <u>Star Route</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>MILTON</u> Last <u>FORD</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873 MARCH 8</u>	9. AGE (in years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u> IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Wood County Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Milton S. Ford</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Olds</u>		14. NAME OF HUSBAND OR WIFE <u>GRACE FORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>GRACE FORD Star Rt. FREMONT, MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Systemic</u> DUE TO (c) <u>334X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>(5:45 PM)</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>12-25-59</u> to <u>12-25-59 (10:55 PM)</u> and last saw him alive on <u>12/25/59</u> Death occurred at <u>10:55 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frank E. Danells</u>			22b. ADDRESS <u>Poplar Bluff Mo</u>		22c. DATE SIGNED <u>12-29-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL MEMORIAL</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY NORTH. MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>MCSADDEN VAN BUREN, MO</u>		25. DATE RECD. BY LOCAL REG. <u>12/31/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

S. 300
v. 1-57

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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 *Allen C. McJannet*

Licensed Embalmer No. *4543*

P. O. Address *Van Buren, Mo*

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.