

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5.4 3 3

FILED VS. JAN 8 1960

212139

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY None | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY None | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 35 yrs | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5636 Terry Avenue Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Ameal Middle _____ Last FORD | | | 4. DATE OF DEATH Month Dec. Day 29 Year 1959 | |
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|-----------------------|----------------------------------|---|---|---|--|--|
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 99 abt. '99 | 9. AGE (last birthday) abt 60 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | 10b. KIND OF BUSINESS OR INDUSTRY General Motors | 11. BIRTHPLACE (City and state or country) Brookhaven, Miss. | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Will Ford | 13b. MOTHER'S MAIDEN NAME Unavailable | 14. NAME OF HUSBAND OR WIFE Missie Ford |
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| 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. 492-09-5015 | 17. INFORMANT Address Missie Ford, 5636 Terry Ave. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks |
| IMMEDIATE CAUSE (a) | LIVER FAILURE - SEPSISEMIA | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) HEPATIC CIRRHOSIS - SEPTISEMIA | |
| | DUE TO (c) PERIURETHRAL ABSCESS | 609+ |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
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| 21. I attended the deceased from 12-13-59 to 12-29-59 and last saw her alive on 12/29/59 Death occurred at 4:15 AM on the date stated above, and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE (Degree or title) Peter Lekkas M.D. | 22b. ADDRESS ST. LUKE'S HOSPITAL 5535 Delmar Blvd. St Louis 12, Mo | 22c. DATE SIGNED 12/29/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 1/2/60 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. | 23d. LOCATION (City, town, or county) (State) Berkeley City Mo. |
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| 24. FUNERAL DIRECTOR ADDRESS Cunningham & Moore, 2405 Marcus Av | 25. DATE RECD. BY LOCAL REG. DEC 30 1959 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb

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 John R. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.