

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038189

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 366 Primary Registration District No. _____ Registrar's No. 424

FILED NOV 7 1961

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township	Length of stay in 7b 4Yrs.27das.	c. CITY OR TOWN Cape Girardeau	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 230 1/2 So. Sprigg St.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last RALPH L. FORD			4. DATE OF DEATH Month Day Year October 27, 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1916	9. AGE (last birthday) 45	IF UNDER 1 YEAR Months Days 1 0	IF UNDER 24 HR Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Never employed		11. BIRTHPLACE (City and state or country) White Water, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Ernest Ford		13b. MOTHER'S MAIDEN NAME Mary K. Summers		14. NAME OF HUSBAND OR WIFE		
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. None		17. INFORMANT Records, State Hospital No. 4, Farmington, Mo.		Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - - - - - instantaneous		INTERVAL BETWEEN ONSET AND DEATH At least 1 year.
DUE TO (b) Hypertensive cardiovascular renal disease - - -		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mental deficiency.		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

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 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

21. I attended the deceased from June 8, 1960 to Oct. 27, 1961 and last saw ~~him~~ ^{XXXX} alive on Oct. 27, 1961
Death occurred at 2:50 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John Brennan MD</i>		22b. ADDRESS State Hospital No. 4 Farmington, Missouri		22c. DATE SIGNED 10-30-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 30, 1961	23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept.	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR ADDRESS Via Cozean Funeral Home, Farmington, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 24, 1961	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>	

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 Wash. U. Med. School, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed M. W. Proader

Licensed Embalmer No. _____

P. O. Address _____

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.