

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

File No. **3915**
Registered No. **28**
St. _____ Ward)

1. PLACE OF DEATH
County Adair Registration District No. 4
Township _____ Primary Registration District No. 3001
City Linksville St. _____ Ward)

2. FULL NAME John James Ward
(a) Residence No. 315 N. Frank St., 20 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Ward

6. DATE OF BIRTH (MONTH, DAY AND YEAR) mar 28, 1854

| | | | | |
|--------|-----------|-----------|-----------|--|
| 7. AGE | YEARS | MONTHS | DAY | IF LESS than 1 day, hrs. or min. |
| | <u>70</u> | <u>10</u> | <u>22</u> | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Anna Ward (Address) Linksville Mo.

15. FILED 7/22 1930 E. B. Becker REGISTRAR
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-20 1930

17. I HEREBY CERTIFY That I attended deceased from 12-10 1930 to 2-20 1930 that I last saw him alive on 2-20 1930 and that death occurred, on the date stated above, at 9:48 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis
92B

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) 90A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) C. M. C. Wilcox M. D.
, 19 (Address) Linksville Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

| | |
|--|---------------------------------------|
| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Lucylyn</u> | DATE OF BURIAL <u>Feb 23, 1930</u> |
| 20. UNDERTAKER <u>Summer Son</u> | ADDRESS <u>Linksville</u> |

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARENTS

Wiley
4-1930

1930-2 20
1859-3 28

90-10=22

28
50