REC'D AUG 11 1939

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

25136
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan 3 Registration District No. 86
(b) Township Washington 1 Primary Registration District No. 5127 Registered No. 740
or
(c) City ..... (d) Street No. County Infirmary St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 630 Ben Soward
(a) Residence, No. County Infirmary St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Late Mollie Soward
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29-1856
7. AGE YEARS 82 MONTHS 11 DAYS 16 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None (Unk)
9. Industry or business in which work was done, as saw mill, bank, etc. None
10. Date deceased last worked at this occupation (month and year) None
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Platt Co. Mo

FATHER
13. NAME Henry Soward
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown unknown

MOTHER
15. MAIDEN NAME unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weston Mo

17. INFORMANT (ADDRESS) Tillie Smith 1823 Delton
18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 7/18/1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ramsey Mortuary 1602 Messanie
20. FILED July 18, 1939 H. J. Nestlebush P.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 - 1939
22. I HEREBY CERTIFY, That I attended deceased from 1/15/39, 19..., to 7/15/39, 19...
I last saw him alive on 7/13/39, 19... Death is said to have occurred on the date stated above, at 2 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
General Arteriosclerosis	Dont Know
97	

Other contributory causes of importance:

Prostatic Hypertrophy	Dont Know

Name of operation — Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) A. E. Holley, M.D.
85 (Address) 8 N. Edmond St. St. Joseph Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.