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NOV 12 1940
Registration District No. **227**

Primary Registration District No. **1002**

Registrar's No. **3825**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days)

In this community 30 yrs

3. (a) PRINT FULL NAME SAMUEL WARD

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male **5. Color or race** white

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Effie Ward

6. (c) Age of husband or wife if alive no record years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years About 72 Months - Days - If less than one day hr. 1 min.

9. Birthplace (City, town, or county) (State or foreign country) KS

10. Usual occupation Store Keeper 9

11. Industry or business Self

12. Name Ward

18. Birthplace (City, town, or county) (State or foreign country) no record

14. Maiden name no record

15. Birthplace (City, town, or county) (State or foreign country) no record

16. (a) Informant R. W. Ward

(b) Address 5824 Prospect

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct-3-1940
(Month) (Day) (Year)

(c) Place: burial or cremation Pomona Rd.

18. (a) Signature of funeral director Wm. C. Foster

(b) Address 918 Brooklyn

19. (a) Oct. 2, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 505 Independence Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2nd year 1940 hour 5 minute 00 A. M.

21. I hereby certify that I attended the deceased from 9-12-40 1940 to 10-2-40 1940;
that I last saw him alive on 10-2-40 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Duration

Due to 59

Due to

Other conditions Coronary sclerosis; Encephalomalacia.
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations

Of autopsy See above

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Wiley R. Thayer (M., D., or other)
Med. Dir. K. C. Gen. Hospital, C. Mo. Date signed

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 E. H. Wise

Licensed Embalmer No. 2570

P. O. Address F. O. W.

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

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3825-

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town R. 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

3. (a) PRINT FULL NAME Samuel Ward
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years abt 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace no record
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) Oct 2 1946 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

Date to _____
Date to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature Regina R. Thorne (M. D. or other)
Address Med Dir. U. C. Gen Hosp Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed.....

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 this body is not embalmed, fact should be so stated above.