

FILED NOV 15 1940
477

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 3021

Registrar's No. 115

1. PLACE OF DEATH:

(a) County JASPER
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jane Chinn Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether)
In this community 40 years
years, months or days

3. (a) PRINT FULL NAME JAMES E. WARD

3. (b) If veteran, name war XXX 3. (c) Social Security No. XX

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Anna Ward 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 2 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 2 22 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Elijah Ward

13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Bigford

15. Birthplace Unknown Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant W. B. Ward

(b) Address St. Louis, Missouri

17. (a) Burial (b) Date thereof Oct. 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Williams Cemetery

18. (a) Signature of funeral director Langley M. Mott

(b) Address 1502 Poplar St. Joplin, Mo.

19. (a) OCT. 25 1940 (b) J. E. Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County JASPER
(c) City or town Webb City
(If outside city or town limits, write "RURAL")
(d) Street No. 615 North Town
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24
year 1940 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 10 1940 to Oct 24 1940
that I last saw him alive on Oct 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction
Duration _____

Due to _____

Due 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? 371

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

23. Signature J. E. Johnson (M. D. or other) _____

Address Webb City, Mo. Date signed 10/25/40

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

MOTHER FATHER

122A

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin Mo

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

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

MO. 2B
2-21-40
I X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35391

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 417

Primary Registration District No. 3021

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County. Jasper

(b) City or town. Webb city
(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)

3. (a) PRINT FULL NAME James E. 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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years Months Days If less than one day

65 2 22 h. _____ min.

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

10. Usual occupation

11. Industry or business

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 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b)

(Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month Oct day 24 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

IMMEDIATE CAUSE OF DEATH

Intestinal obstruction

Due to two opinions were that it was not malignant, as no post mortem was made I do not know - but believe that it was malignant

Other conditions (include diagnosis within 3 months of death) _____

Major findings or operations _____

Of autopsy N. M. R.

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 R. M. Stormont (M. D. or other) _____
Webb city, Mo
Address _____ Date signed _____

SUPPLEMENTAL

