

FILED JUN 18 1942

Registration District No. 83

Primary Registration District No. 1001

Registrar's No. 532

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3219 Doniphan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 3219 Doniphan
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1942 hour 11 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from April 20
1942 to May 22 1942
that I last saw her alive on May 22 1942
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral hemorrhage Duration _____

3. (a) PRINT FULL NAME Anna Ward

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

(b) Name of husband or wife W. M. Ward 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 20 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Laughlin

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

14. Maiden name Sarah Kennedy

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

16. (a) Informant Mrs. Alda Ward

(b) Address Omaha, Neb.

17. (a) Burial (b) Date thereof May 25 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address 1946 Calhoun

19. (a) 5-23-42 (b) Rose Heyog
(Date received local registrar) (Registrar's signature)

Due to Hypertension

Due to Stroke

Other conditions 830
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy _____

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. N. Gassen (M.D. or other) R.O.

Address Katipatank's Bldg Date signed May 24 1942

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

May 22 - 42

Registered Apprentice No.

working under my personal supervision.

Signed

John H. Hurley

Licensed Embalmer No. *4050*

P. O. Address. *St. Joseph Mo*

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 17486

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St Joseph
(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 Anna Ward
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Apr 20 1902
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 10
If less than one day

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

10. Usual occupation _____
 11. Industry of 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) 5-23-42 (b) Rose Herzog
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May Day 12
 year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____
 that I saw him/her _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

S-17486