

S. No. 2
M-5-42
7-5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 20 1942

3723

Registration District No. 149

Primary Registration District No. 1602

Registrar's No.

48
33
8

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas Mo

(c) Name of hospital or institution:
7644 Howell Rd 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME John T. 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 married

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

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased November 14 - 1865
(Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days 24 If less than one day hr. min.

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

10. Usual occupation Painter

11. Industry or business Retired

12. Name William Ward

13. Birthplace Quincy Illinois 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Sanford

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

16. (a) Informant Mrs Ethel Lester

(b) Address Salisbury, Mo

17. (a) Burial (b) Date thereof 10-10-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keytesville, Mo

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

(b) Address W. C. Mo

19. (a) 10-9-42 (b) W. M. Groves
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton 2

(c) City or town Keytesville Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8 year 1942 hour 5:50 minute 10 P. M.

21. I hereby certify that I attended the deceased from Feb 1941 to Date 1942, to Oct 8, 1942 that I last saw him alive on Oct 8th 1942 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Due to arterio sclerosis

Due to local teeth 430

Other conditions Arterio sclerosis (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) (2) Means of injury

23. Signature W. M. Groves (M. D. or other) Address 3204 E 523 Date signed 10-8-42

361

Mr Jackson
with a ...
320465-2

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... *Theron R. Edman*

Licensed Embalmer No. *2937*

P. O. Address... *K.C. 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.