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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 13 1943

Registration District No. ____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14730

Primary Registration District No. 5655

Registrar's No. 51

1. PLACE OF DEATH:
(a) County: Lawrence
(b) City or town: Mount Vernon Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 days (Specify whether years, months or days)
In this community: 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis Co
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: Crescent Road, Valley Park
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Aurelia Ward
3. (b) If veteran, name war: —
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Anthony Ward
6. (c) Age of husband or wife if alive: unknown years
7. Birth date of deceased: Aug. (Month) 26 (Day) 1917 (Year)

8. AGE: Years 25 | Months 7 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace: England (City, town, or county) Ark. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____

MOTHER
12. Name: John Compton
13. Birthplace: Summerville (City, town, or county) Ark. (State or foreign country)

FATHER
14. Maiden name: Carrie Mitchell
15. Birthplace: Summerville (City, town, or county) Ark. (State or foreign country)

16. (a) Informant: Mrs. Michael Reed Clerk
(b) Address: Mo. State San; Mt. Vernon, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/12/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Park
18. (a) Signature of funeral director: [illegible]
(b) Address: 3050 [illegible]
19. (a) April 16 43 (Date received by local registrar) (b) Lucy Campbell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 6 year: 1943 hour: 8 minute: 25 P.M.
21. I hereby certify that I attended the deceased from March 28, 1943, to April 6, 1943, that I last saw her alive on April 6, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis — Duration: over 3 months
Due to: ____
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: ____
Of autopsy: ____

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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? (Specify type of place)
While at work? (e) Means of injury: ____
23. Signature: [illegible] (M. D. or other)
Address: Mo. State Sanatorium Date signed: 4/6/43

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(Licensed Embalmer's Statement on Reverse Side)

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 William C. McDowell, Registered Apprentice No. ..... working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2117

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.