

No. 2
5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6646

FILED FEB 24 1944

State File No.

Registration District No.

Primary Registration District No. 1000

Registrar's No. 134

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town De Kalb
(c) Name of hospital or institution: Merced Hospital
(d) Length of stay: 3 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County De Kalb
(c) City or town WEATHERS
(d) Street No.
(e) Citizen of foreign country? (Yes or No) 1

3. (a) PRINT FULL NAME LUTHER THOMAS WARD
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10 year 1944 hour 5 minute 20 A.
21. I hereby certify that I attended the deceased from Feb 17 1944 to Feb 10 1944
that I last saw him alive on Feb 10 1944 and that death occurred on the date and hour stated above.
Immediate cause of death Ulcers

4. Sex M 5. Color of face W 6. (a) Single, widowed, married, divorced M
(b) Name of husband or wife Marys Ward 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased: Nov. 21-1874

Due to Ruptured Gallbladder
Due to

8. AGE: Years 69 Months 7 Days 19 If less than one day hr. min.
9. Birthplace: De Kalb Co. Mo

Other conditions: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: PHYSICIAN
Of operations: Underline the cause to which death should be charged statistically.
Of autopsy:

10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name John D. Ward
13. Birthplace Mo.
14. Maiden name Amazilla Reed
15. Birthplace Missouri
16. (a) Informant Luther T. Ward
(b) Address 118 Van Buren, Amosville, Mo
17. (a) Removal (b) Date thereof 2-10-44
(c) Place burial or cremation Wapella Cem.
18. (a) Sign W. H. MEYER, HOME
(b) Address W. H. MEYER, HOME
19. (a) 2-10-44 (b) W. H. MEYER

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 124

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 (Specify whether _____)

3. (a) PRINT FULL NAME Luther J. 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 _____ years
7. Birth date of deceased Nov 21 1927
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days _____ If less than one day, _____ min.

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 10 Year 1944 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ 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 slues Duration _____

Due to Ruptured Gallbladder
Due to inflammation with stones
Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUEST / 26
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 [Signature] Date signed Mar 7/44
Address St. Joseph mo

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

SUPPLEMENTAL REQUEST

MAR

000460