

FILED APR 7 1944

Primary Registration District No. **1002**

Registrar's No. **1403**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3903 East 18th St**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **23 Years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3903 East 18th, St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Charles R. Ward**  
(b) If veteran, name war **No** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **26th**,  
year **1944** hour **9** minute **A.** M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from **March 25**, 19**44**, to **March 26**, 19**44**, that I last saw him alive on **March 25**, 19**44**, and that death occurred on the date and hour stated above.

8. AGE: Years **23** Months **3** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: **Hypostatic Lobes pneumonia**  
Due to **Inactivity caused by Infantile paralysis Biceps**  
Due to \_\_\_\_\_

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation **Invalid**

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name **Robert B. Ward**  
13. Birthplace **Va.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Maude Canfield**  
15. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert B. Ward**  
(b) Address **3903 East 18th, St.**

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? \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **3/29/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**  
(d) Signature of funeral director **Earp Funeral Home**  
(b) Address **4139 East 15th, St.**

19. (a) **3-29-44** (b) **N. E. Brown**  
(Date received local registrar) (Registrar's signature)

23. Signature **J. H. Miller** M. D. or other \_\_\_\_\_  
Address **4713 1/2 E. 24th** Date signed **March 27**

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

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**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.....

*John B. Camp*  
2955-  
18 C Mo

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.**