

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30353

State File No.

FILED OCT 9 1944

Registration District No.

Primary Registration District No. 1002

Registrar's No. 3935

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 8 1/2 hrs.
(Specify whether
 In this community unknown
years, months or days)

3. (a) PRINT FULL NAME Chas. H. Ward3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced unfr
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 28 years
 7. Birth date of deceased Oct. 28 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	10	29	hr. min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)10. Usual occupation none

11. Industry or business

MOTHER FATHER { 12. Name Albert Ward
 13. Birthplace Ill. 1
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Kent
 15. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk(b) Address K. C. General Hospital No. 117. (a) Burial (b) Date thereof Sept-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Crematory18. (a) Signature of funeral director Wm. A. Johnson(b) Address City Medication19. (a) 9-30-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
 (d) Street No. 514 1/2 Main
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1944 hour 6 minute 10 P. M.21. I hereby certify that I attended the deceased from Sept. 26 1944 to Sept. 27 1944;
that I last saw him alive on Sept. 27 1944;
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral hemorrhage
DurationDue to 83a

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
 Of operations None
 Of autopsy None
 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? _____

(e) Means of injury While at work?23. Signature U. E. Walker (M. D. or other) 9-28-44Address Med. Dir. Gen'l Hosp Date signed _____

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.