

No. 8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF PUBLIC HEALTH  
**FILED FEB 28 1946**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**6248**

State File No. ....

Registration District No. 169

Primary Registration District No. 4260

Registrar's No. 23

**1. PLACE OF DEATH:**

(a) County Iron

(b) City or town Baring  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Knox 52

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

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** John Franklin Ward

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month January day 8  
year 1946 (hour 10 minute 30 AM)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov - 10 - 1881  
(Month) (Day) (Year)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Hit by Santa Fe train engine at Baring Mo.

8. **AGE:** Years 73 Months 1 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

Due to Out Head of Body

Due to \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Farming

**MOTHER FATHER**

12. Name John Ward

13. Birthplace Adams Co. Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Bulz

15. Birthplace Wip. Indiana  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**PHYSICIAN** \_\_\_\_\_ Underline the cause to which death should be charged statistically.

16. (a) Informant Allen Ward

(b) Address Hurdland, Missouri

17. (a) Burial (b) Date thereof Jan - 10 - 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yimsville, Edina Mo.

18. (a) Signature of funeral director Neil Hudson

(b) Address Edina, Missouri

19. (a) Jan - 10 - 46 (b) Nellie Nunnet  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: 52

(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 3

23. Signature Neil Hudson (M.D. or other) 3

Address Edina, Missouri Date signed 1-9-46

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

RECEIVED

Health Officer No. 10

License No. Number 2-46-252

Date Filed FEB 25 1946

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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.....

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.**

Registration District No. 169

Primary Registration District No. 4260

1. PLACE OF DEATH: Knox  
 (a) County Knox  
 (b) City or town Baring  
 (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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days

3. (a) PRINT FULL NAME John F. 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 s  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
 7. Birth date of deceased Nov - 10  
 (Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ Unless than one day \_\_\_\_\_  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Reversed Head from front body.

Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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) Accident

(b) Date of occurrence Jan - 8 - 1946

(c) Where did injury occur? Baring, Knox, Mo.  
 (City, town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Hit by train on AT & S. tracks at Baring Mo.  
 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Spitz Hudson (M.D. or other) \_\_\_\_\_

Address Edina Mo. Date signed 2-8-46

SUPPLEMENTARY

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

2 51. 103

6248