

No. 2  
1-5-43  
5-17-39  
I X3667

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

FILED JUL 2 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACOBSON

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

(c) Name of hospital or institution:  
MONTROSE APT. HOTEL 40<sup>TH</sup> & MAIN 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 45 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACOBSON #8

(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL") 3

(d) Street No. MONTROSE APT. HOTEL 40<sup>TH</sup> & MAIN ST  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME MR ROBERT EDWARD WARD SR

(b) If veteran, name war No

(c) Social Security No. 500-22-5287

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 17<sup>TH</sup>  
year 1946 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from  
JUNE 16, 1946, to JUNE 17, 1946;  
that I last saw him alive on JUNE 17, 1946;  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. FRANCES LEE WARD

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased JANUARY 7, 1877  
(Month) (Day) (Year)

Immediate cause of death STRANGULATION OF GALLBLADDER  
Duration 26 HR.

8. AGE: Years 69 Months 5 Days 10  
If less than one day hr. min.

Due to CARCINOMA, HEAD OF PANCREAS  
26 hr.

9. Birthplace GOLDEN CITY MISSOURI  
(City, town, or county) (State or foreign country)

Due to ARTERIOSCLEROTIC HEART DISEASE  
3 mo.

10. Usual occupation RETIRED-NEWSPAPER CORRESPONDENT

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

MOTHER FATHER

11. Industry or business K.C. JOURNAL-POST

12. Name REV. ROBERT B. WARD

13. Birthplace UNIONVILLE TENNESSEE  
(City, town, or county) (State or foreign country)

14. Maiden name LAURA MORRICK

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

16. Informant Mrs. M. E. Ward  
Address Montrose Hotel

17. (a) BURIAL (b) Date thereof JUNE 19, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director W. H. Newcomer's Sons  
(b) Address 1401 BRUSH CREEK BLDG.  
6-18-46 (c) Signature of Registrar Geraldine Holmes

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature T. Reid Jones (M. D. or other) M. D.  
Address 1107 Bryans Bldg. K.C. Mo. Date signed 6-17-46

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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..... *Bernard L. Horan* .....

Licensed Embalmer No. *4250* .....

P. O. Address..... *W.C. Mo* .....

**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.**