

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_

Registrar's No. 8114

**FILED 319 30 1946**

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

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

31149

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
St. Mary's Infirmary  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2926 Laclede Ave.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN ANNA WARD

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Female 5. Color or race C

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

6. (b) Name of husband or wife Sam Ward

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

7. Birth date of deceased Unavailable 1910  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>Abt.</u>	<u>36</u>			hr. _____ min. _____

9. Birthplace Scott Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Maid

11. Industry or business Private family

12. Name John Wesley Gilliam

13. Birthplace Atlanta Ga.  
(City, town, or county) (State or foreign country)

14. Maiden name Georgia Maddox

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

16. (a) Informant Anna Mae Gentry

(b) Address 2926 Laclede Ave.

17. (a) Burial (b) Date thereof 9-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) SEP 20 1946 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17th  
year 1946 hour 6 minute 00 P. M.

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

Immediate cause of death

Cerebral Hemorrhage  
Septicemia Post Partum  
Non-puerperal  
Blow Abscess Non-tubercular  
Cont. Malaria

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

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

Major findings:  
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] (M. D. or other) \_\_\_\_\_

Address 1300 Clark Ave.

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.....

Thomas J. Gates

, Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 4259

P. O. Address. 4107 Finney Ave.

**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.**