

**FILED DEC 23 1946**

Primary Registration District No. **4226**

Registrar's No. **114**

**1. PLACE OF DEATH:**  
(a) County **Holt**  
(b) City or town **Corning, Mo**  
(c) Name of hospital or institution: **Corning, Mo. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **82 years**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Holt**  
(c) City or town **Corning, Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

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

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Nov** day **30**  
year **1946** hour **4** minute **15 A.M.**

**4. Sex** **Female** **5. Color or race** **White**  
**6. (a) Single, widowed, married, divorced** **Married**  
**6. (b) Name of husband or wife** **J. W. Ward** **6. (c) Age of husband or wife if alive** **77** years  
**7. Birth date of deceased** **September 18, 1864**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** **Nov 26**, 1946, to **Nov 30**, 1946;  
that I last saw her alive on **Nov 30**, 1946;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>82</b>	<b>2</b>	<b>12</b>	hr. _____ min. _____

Immediate cause of death **Circulatory Failure result of Hemorrhage of Urinary Bladder**  
Due to **Malignancy of bladder** **9**  
Duration \_\_\_\_\_

**9. Birthplace** **near Corning, Mo.**  
(City, town, or county) (State or foreign country)

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.

**10. Usual occupation** **Housewife**

**11. Industry or business** **In the home**

**12. Name** **Robert Young**

**13. Birthplace** **Unknown, Missouri**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **Unknown**

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

**16. (a) Informant's own signature** **J. W. Ward**  
(b) Address **Corning, Mo.**

**17. (a) Burial** (b) Date thereof **12/2/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Mount Hope near Corning**

**18. (a) Signature of funeral director** **Willie L. Scholes**  
(b) Address **Craig, Mo.**  
(c) Date received local registrar **Dec 18** (d) Registrar's signature **J. Chry**

**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** **J. Bruce McRae** (M. D. or other) **DO**  
Address **Craig, Mo.** Date signed **11/30/46**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DISTRICT HEALTH OFFICE  
Cameron, Mo.

**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.....

*myself*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Wilber L. Schoole*.....

Licensed Embalmer No. *3997*.....

P. O. Address *Craig, Mo*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*  
Registrar's No. *114*

Registration District No. *139*

Primary Registration District No. *4226*

1. PLACE OF DEATH:  
(a) County *Holt*  
(b) City or town *Corning*  
(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

2. (a) PRINT FULL NAME *Lewella Y. Ward*  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *m*  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased *Sept 18 1930*  
(Month) (Day) (Year)

8. AGE: Years *32* Months *2* Days *20* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 *Jan* 19*46* year, hour \_\_\_\_\_ minute *15* A.M.  
21. I hereby certify that I attended the deceased from *Nov* \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to *Cancer of bladder*  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: *5015*  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 *J. Bruce McKee* M. D. or other \_\_\_\_\_  
Address *Corning Mo* Date signed *Jan 27/46*

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

SUPPLEMENTARY

40395