S. No. 300
M—10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 8 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37489

Registration District No. 243 | Primary Registration District No. 5831 | Registrar's No. 33

73
9

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Rural Franklin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 33 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Stella, Mo. R#
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Sarah Emma Ward
3. (b) If veteran, name war ____ | 3. (c) Social Security No. ____
4. Sex Female / | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert L. Ward | 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased July 28 (Month) (Day) 1875 (Year)

8. AGE: Years 73 | Months 3 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Lee County (City, town, or county) Virginia / (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____
FATHER
12. Name Walter Garber
13. Birthplace ____ (City, town, or county) Virginia / (State or foreign country)
MOTHER
14. Maiden name Delia Ward
15. Birthplace ____ (City, town, or county) Virginia / (State or foreign country)
16. (a) Informant Robert L. Ward
(b) Address Stella, Mo. R#1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (Month) (Day) (Year)
(c) Place: burial or cremation Macedonia Cem. Stella
18. (a) Signature of funeral director Wm Morris Boyne
(b) Address Wheaton, Mo.
19. (a) 12-4-1948 (Date received local registrar) (b) Alpha Dyer (Registrar's signature) 2 in 9

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26
year 1948 hour 8 minute P. M.
21. I hereby certify that I attended the deceased from June, 1946 to Nov 26, 1948
that I last saw her alive on Nov. 26, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebro vascular accident	1½ hours
Due to: Cardio renal hypertensive disease	2 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death) 93	

Major findings:
Of operations ____
Of autopsy Copy.

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature Charles O Chest (M. D. or other) DD
Address Granby, Mo. Date signed 11-30-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Newton Health Unit
District File Number 1248-425
Date Filed 12-6-48

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 Wm Morris Pogue

Licensed Embalmer No. 37421

P. O. Address Wheaton, 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.