

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17782**
4287
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Bond Bond: 999	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Keyesport	
c. LENGTH OF STAY (in this place) 0		d. STREET ADDRESS (If rural, give location) 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri-Baptist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) JENELL b. (Middle) WARD c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) May 12 1949		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH July 2, 1906		9. AGE (In years last birthday) 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John W. Ward	13b. MOTHER'S MAIDEN NAME Ella Elliott	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME John W. Ward, Keyesport, Illinois	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tubercle - Spinal meningitis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Keyesport Bond Illinois
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from **2/28**, 19**49**, to **5/12**, 19**49**, that I last saw the deceased alive on **5/12/49**, 19**49**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS 4952 Maryland Avenue	23c. DATE SIGNED 5/12/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE May 12, 1949	24c. NAME OF CEMETERY OR CREMATORY unknown	24d. LOCATION (City, town, or county) (State) Greenville, Illinois
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DATE REC'D BY LOCAL REG. MAY 13 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE C. R. Lupton & Sons, St. Louis, Missouri	ADDRESS
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25-5

[Handwritten signature]

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *X* *Clarence H. Murray*

Licensed Embalmer No. *400*

P. O. Address *St. Louis, 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.