

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32303

State File No.

318

1003

8607

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
c. LENGTH OF STAY (In this place)				d. STREET ADDRESS (If rural, give location) 5344 Queens Avenue,					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				7					
3. NAME OF DECEASED (Type or Print)		a. (First) JOSEPHINE G. WARD		b. (Middle)		c. (Last)			
4. DATE OF DEATH		10-5-1949		5. SEX female		6. COLOR OR RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, NEVER MARRIED		8. DATE OF BIRTH 7-11-1890		9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 2 Days 24			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME James C. Ward		13b. MOTHER'S MAIDEN NAME Catherine Walsh		14. NAME OF HUSBAND OR WIFE none-					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Mr. James F. Ward, 5344 Queens Ave.		ADDRESS			
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Central Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiovascular Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 331X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
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) 1310					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HX					
22. I hereby certify that I attended the deceased from Sept 19, 1949, to Oct 5, 1949, that I last saw the deceased alive on Oct 4, 1949, and that death occurred at 2 A.M., from the causes and on the date stated above.									
23a. SIGNATURE Alphine McMahon, M.D.				23b. ADDRESS 806 No. Theatre Bldg		23c. DATE SIGNED Oct 5 '49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 10-8-1949		24c. NAME OF CEMETERY OR CREMATORY Int. Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. OCT 6 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Fun. Dir. 2849 No. Euclid					

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Robert L. Brinkman
Licensed Embalmer No. 3553

P. O. Address St. Louis

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.