

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **43412**
 Registrar's No. **11522**

FILED JAN 16 1952

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY 9120	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Mt. Vernon	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS 4 Huernan	

3. NAME OF DECEASED (Type or Print) a. (First) Bertha	b. (Middle) A	c. (Last) Ward	4. DATE OF DEATH (Month) (Day) (Year) 12-26-51
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-4-1889	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Waterloo, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Sebastian Reifschneider	13b. MOTHER'S MAIDEN NAME Mathilda Franz	14. NAME OF HUSBAND OR WIFE Arthur Ward
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME R. B. Guthrie, Mt. Vernon, Illin	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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis 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 checked="" 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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334X
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22. I hereby certify that I attended the deceased from **Dec 7, 1951**, to **Dec 26, 1951**, that I last saw the deceased alive on **Dec 25, 1951**, and that death occurred at **7 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Robert Swanson MD (Degree or title)	23b. ADDRESS Paul Brown Ref S. Mt. Vernon	23c. DATE SIGNED Dec 26 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-27-51	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Mt. Vernon, Illinois
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DATE REC'D BY LOCAL REG. DEC 27 1951	REGISTRAR'S SIGNATURE Earl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Myers Funeral Home, Mt. Vernon,	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

2001 9 21 11:45

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 *Benjamin* _____

Licensed Embalmer No. *17366* _____

P. O. Address. *Howe St* _____

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.