

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

363336

STATE FILE NUMBER

FILED NOV 13 1957

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 206

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR (Prairie) Independence TOWN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Independence Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hospital Length of stay in 1b 1 Yr.		d. STREET ADDRESS (If outside, give location) 3424 Arlington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle H Last WARD			4. DATE OF DEATH Month 11 Day 2 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10 1866
9. AGE (In years at birthday) 92		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY X X X	11. BIRTHPLACE (City and state or country) Edinburgh Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A		13a. FATHER'S NAME Robert Ward	
13b. MOTHER'S MAIDEN NAME Phoebe Valentine		14. NAME OF HUSBAND OR WIFE Marie A. Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y no , or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Mrs. Edith Ward, 3424 Arlington, Indep. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>1-1-57</u> to <u>11-2-57</u> and last saw her/him alive on <u>10-30-57</u> Death occurred at <u>9:35 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Paul W. ...</i>		22b. ADDRESS <i>Johnson County, Mo.</i>	22c. DATE SIGNED <u>11-3-57</u>
23a. BURIAL, CREMATION, OR OTHER (Specify) Burial	23b. DATE 11-4-1957	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Mem. Gardens	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels Kan. City, Mo.		25. DATE RECD. BY LOCAL REG. 11-3-1957	26. REGISTRAR'S SIGNATURE <i>N.B. Langford</i>

Nov 17 1961
Mr. David Waxman
49th Street
Manhattan, N.Y.
100-12

935 Avenue
11-2-57

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 _____
Signature of Student Embalmer

Signed *R. J. Nofziger*
Licensed Embalmer No. *5938*
P. O. Address *P. O. 710*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

NOV 12 1961