

Health,
& Welfare
S. Public
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FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **38300**
REGISTRAR'S NO. **10502**

Registration District No. **318** Primary Registration District No. **1003**

S. 300
v. 1-57

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis ²⁰⁵⁹	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If outside, give location) 5189 Cabanne Ave.	
3. NAME OF DECEASED (Type or print) First David Middle William Last Ward		4. DATE OF DEATH Month November 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 type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (City and state or country) Lewisburg West Va.
13a. FATHER'S NAME Robert Ward		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Eula
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. —	17. INFORMANT Address Eula Ward 5189 Cabanne Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANTEROSEPTAL MYOCARDIAL INFARCT DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 420.0H PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADENOCARCINOMA OF PROSTATE			INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 10-10-57 to 11-2-57 and last saw ^{him} alive on 11-2-57 Death occurred at 8:45a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert F. Owen, M.D.		22b. ADDRESS 1515 Lafayette	22c. DATE SIGNED 11-2-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-5-57	23c. NAME OF CEMETERY OR CREMATORY Upper Alton	23d. LOCATION (City, town, or county) (State) Alton Ill
24. FUNERAL DIRECTOR Carson Lewis ADDRESS 603 Henry St.		25. DATE RECD. BY LOCAL REG. NOV 5 57	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. J.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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STATE OF ILLINOIS
DEPARTMENT OF HEALTH

Year of Embalming

Sex

Color

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 *Carroll Lewis*

Licensed Embalmer No. *5796*

P. O. Address *Alton Ill.*

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.