Health, & Welfare Public Service

. 300
1-57

Dr. Fitch

FILED FEB 24 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005227
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 173

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN SPRINGFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) KIMBROUGH REST HOME — Length of stay in 1b 1½ YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY GREENE
c. CITY OR TOWN SPRINGFIELD 0396 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) KIMBROUGH REST HOME — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: VIRGINIA Middle: Last: WARD
4. DATE OF DEATH Month Day Year: FEB. 17 1959
5. SEX: FEMALE 1
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: AUG. 19 1867
9. AGE (In years last birthday): 91 — 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): HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): ALLEGHENY CO. PENN. 1
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: JOHN STEIN
13b. MOTHER'S MAIDEN NAME: SARAH JANE JOHNSTON
14. NAME OF HUSBAND OR WIFE: CHARLES S. WARD (DEC.)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: MRS. CLARK HILL Address: SPRINGFIELD, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac - Renal - Vascular Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 442 X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

21. I attended the deceased from 1-20-59, to 2-4-59 and last saw her/him alive on 2-4-59
Death occurred at 12:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm Fitch (Degree or title) MD
22b. ADDRESS Springfield Mo
22c. DATE SIGNED 2-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2/19/59
23c. NAME OF CEMETERY OR CREMATORY: OAK LAWN CEMETERY
23d. LOCATION (City, town, or county) (State): WEST PLAINS, MO.

24. FUNERAL DIRECTOR ADDRESS: CARTER FUNERAL HOME, WEST PLAINS, MO.
25. DATE RECD. BY LOCAL REG.: 2-18-59
26. REGISTRAR'S SIGNATURE: Effie G. Mellon

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 4734

P. O. Address .....

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.