

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019744

STATE FILING NUMBER 24450
REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. _____

FILED MAY 18 1959

00
57
38
4

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF HOSPITAL OR INSTITUTION Forest Park Municipal Opera.		Length of stay in 1b. Life	d. STREET ADDRESS (If outside, give location) 3212 Dodier St.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last John J. Ward			4. DATE OF DEATH Month Day Year May 4, 1959		
--	--	--	---	--	--

5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1885	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
--------------	------------------------	--	------------------------------------	---------------------------------------	---	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Production Mgr. Municipal Opera	10b. KIND OF BUSINESS OR INDUSTRY Municipal Opera	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
---	--	---	--------------------------------------

13a. FATHER'S NAME Thomas J. Ward	13b. MOTHER'S MAIDEN NAME Dollie Passmore	14. NAME OF HUSBAND OR WIFE
--------------------------------------	--	-----------------------------

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 Mr. John W. Ward, 6100 Kingsbury Blvd.	Address
---	-------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Coronary Arteriosclerosis</i>	DUE TO (c) <i>4201</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 Month, Day, Year a.m. p.m.	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 <i>10-4-58</i> to <i>5-4-59</i> and last saw him alive on <i>5-1-59</i> Death occurred at <i>11:30 am</i> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Gregg Peab M.D.</i>	(Degree or title)	22b. ADDRESS <i>8845 Kingsbury</i>	22c. DATE SIGNED <i>5-5-59</i>
--	-------------------	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 8, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
---	--------------------------	--	--

FUNERAL DIRECTOR OR ADDRESS <i>Arthur J. Donnelly, 3840 Lindell Blvd.</i>	25. DATE RECD. BY LOCAL REG. MAY 6 1959	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D., P.O.</i>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

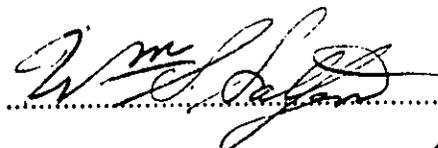
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. 4699
P. O. Address 3840 Linder

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.