

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021752

STATE FILE NUMBER 2595

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>		Length of stay in lb <b>17 YRS</b>		d. STREET ADDRESS (If outside, give location) <b>475 Booth</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Ward</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-1893</b>	9. AGE (In years last birthday) <b>76</b>	10. FUNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (City and state or country) <b>GELOWELL Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>NELSON WARD</b>			13b. MOTHER'S MAIDEN NAME <b>MARJORIE DRYAN</b>		14. NAME OF HUSBAND OR WIFE <b>MARCO WARD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>496-07-9832</b>		17. INFORMANT Address <b>MRS. MARCO WARD 475 BOOTH</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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.) <b>491X</b>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>5-10-59</b> to <b>5-24-59</b> and last saw <sup>him</sup> <b>him</b> alive on <b>5-24-59</b> Death occurred at <b>6:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Abraham Galperin</i>				22b. ADDRESS <b>General Hospital</b>		22c. DATE SIGNED <b>5-25-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>BURIAL</b>		<b>14 MAY 26 59</b>	<b>MT. WASHINGTON</b>		<b>KANSAS CITY, MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <i>Sheil Funeral Home No. 140</i>				25. DATE RECD. BY LOCAL REG. <b>5-25-59</b>	26. REGISTRAR'S SIGNATURE <i>new Marshall</i>		

All diseases in Part I must be causally related.

Abraham Galperin USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**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.....

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.**