

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60=022922**

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 710 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>34 days</u>	c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>41 Drury Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>Ware</u> Last <u>Ward</u>	4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1960</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1915</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>store manager</u>	11. BIRTHPLACE (City and state or country) <u>Millington, Mich.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Perry Lee Ward</u>	13b. MOTHER'S MAIDEN NAME <u>Ila Mae Titworth</u>	14. NAME OF HUSBAND OR WIFE <u>Sylvia Ward</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>NW II 7741 TD 1-30 46</u>	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT Address <u>Mrs. Sylvia Ward, Lebanon, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mediastinal malignancy c metastases microscopic diagnosis not yet available</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>  </u>	
	DUE TO (c) <u>  </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m.	Month, Day, Year <u>  </u> / <u>  </u> / <u>  </u>
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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
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21. I attended the deceased from 5/1/60 to 6/26/60 and last saw her/him alive on 6/25/60  
Death occurred at 1:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Springfield Mo</u>	22c. DATE SIGNED <u>6/29/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shaddy Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Grovesprings, Missouri</u>
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24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-1-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gene C. Sker

Licensed Embalmer No. 4739

P. O. Address Sold, m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.