

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020192

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 79

FILED JUN 6 1961

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township		Length of stay in 1b 4 yrs.	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Hosp. # 3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1535 W. Madison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Wardow Last Wardow			4. DATE OF DEATH Month May Day 14 Year 1961		
-----------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------	--	--

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 2-11-1888	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------	-------------------------------------	--------------------------------------------	------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY USA
---------------------------------------------------------------------------------------------------------------	-----------------------------------	--------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Chris Wardow	13b. MOTHER'S MAIDEN NAME Emma Miller	14. NAME OF HUSBAND OR WIFE Gra ce Wardow
-------------------------------------------	-------------------------------------------------	-----------------------------------------------------

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. Unkown	17. INFORMANT Address Hospital record
-----------------------------------------------------------------------------------------------------------------------	------------------------------------------	-------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia INTERVAL BETWEEN ONSET AND DEATH 40 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Fracture of hip 51 days
	DUE TO (c)

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
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

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.) Accidental fall in Hospital
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 3-24-61

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 **1-11-59** to **5-14-61** and last saw her him alive on **5-14-61**
Death occurred at: **12:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) F.H. Martin M.D.	22b. ADDRESS State Hosp. No. 3	22c. DATE SIGNED 5-14-61
-------------------------------------------------------------	------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 14, 1961	23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
-------------------------------------------------------------	----------------------------------	------------------------------------------------------------------	-------------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS Jewell Windle - Springfield, Missouri	25. DATE RECD. BY LOCAL REG. June 3-1961	26. REGISTRAR'S SIGNATURE Anna E. Jerry
------------------------------------------------------------------------------	----------------------------------------------------	---------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1961 JUN 2 SX

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 _____
Percy F. Milster

Licensed Embalmer No. 4805

P. O. Address Nevada, N.

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.