

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046968

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12417

AMENDED

FILED JAN 11 1962

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY _____
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 5515a Hebert Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
CHARLES H. WARD DECEMBER 29 1961

5. SEX Male 6. COLOR OR RACE Negro 7. Married Never Married
 Widowed Divorced 8. DATE OF BIRTH 6/8/1910 9. AGE (last birthday) 51
 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) Teacher 10b. KIND OF BUSINESS OR INDUSTRY Public Schools 11. BIRTHPLACE (City and state or country) Decatur, Illinois U.S.A. 12. CITIZEN OF WHAT COUNTRY _____

13a. FATHER'S NAME John Ward 13b. MOTHER'S MAIDEN NAME Victoria Grundy 14. NAME OF HUSBAND OR WIFE Zola Ward

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 Zola Ward Address 5515a. Hebert

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) MALIGNANT HYPERTENSION INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
 DUE TO (c) 445X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) UREMIA PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 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 _____

21. I attended the deceased from OCT. 9, 1961 to DEC. 29, 1961 and last saw her/him alive on DEC. 29, 1961
 Death occurred at 10:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M. D. 22b. ADDRESS BARNES HOSPITAL 22c. DATE SIGNED 12/30/61

23a. BURIAL CREMATION, REMOVAL (Specify) Removal 23b. DATE 1/6/62 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery 23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)

24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney ADDRESS _____ 25. DATE RECD. BY LOCAL REG. JAN 2 1962 26. REGISTRAR'S SIGNATURE Loed Smith, M.D.

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 Guyton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.