

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046969

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11147** STATE FILE NUMBER

FILED DEC 18 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY ST. CLAIR	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri	Length of stay in lb 3 Days	c. CITY OR TOWN E. St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Memorial		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1916 1/2 Mc Casland

3. NAME OF DECEASED (Type or print) First Lonnie Middle Hospital Last Ward Jr.			4. DATE OF DEATH Month 11 Day 28 Year 61		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-25-61	9. AGE (last birthday) 11 Months 3 Days	IF UNDER 1 YEAR Months 3 Days	IF UNDER 24 HR Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Lonnie Ward	13b. MOTHER'S MAIDEN NAME Henrietta Davis	14. NAME OF HUSBAND OR WIFE -----
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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 Lonnie Ward, 1916 1/2 Mc Casland	Address E. St. Louis
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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) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) immaturity, ? Brain abnormality DUE TO (c) 760.5		INTERVAL BETWEEN ONSET AND DEATH 11/25-11/28
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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 _____ a.m. _____ p.m.	Month, Day, Year _____
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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 **Nov 27, 61** to **Nov 28, 61** and last saw her/him alive on **9:20 am**
Death occurred at **9:22 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas Z. D. Plastic Surg. Resident	22b. ADDRESS Cardinal Glennon Hosp	22c. DATE SIGNED 11-30
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/1/61	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) (State) Centreville Township, Ill.
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24. FUNERAL DIRECTOR Marion's Office, 2114 Missouri Ave, E. St. Louis, Ill.	25. DATE REC'D. BY LOCAL REG. NOV 30 1961	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 *Harold Prokop*

Licensed Embalmer No. 4356

P. O. Address St. Louis Mo

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.