

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29907

1. PLACE OF DEATH

County Wayne Registration District No. 893 File No. _____
 Township Post Creek Primary Registration District No. 6189 Registered No. 14
 City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME

Ernest Perry DeWard

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 5 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20-25

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
4 | 4 | 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo

10. NAME OF FATHER Rafe Ward

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo

12. MAIDEN NAME OF MOTHER Sophia Bennett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo

14. INFORMANT (Address) Rafe Ward Greenville, Mo

15. FILED Aug 25 1929 Mrs. Hattie McHugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 19 29

17. I HEREBY CERTIFY That I attended deceased from Aug 18, 1929, to Aug 25, 1929 that I last saw him alive on Aug 22, 1929, and that death occurred, on the date stated above, at 3:15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ileo-Colitis

1145 (duration) _____ yrs. _____ mos. 14 ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH. No. DATE OF _____
 WAS THERE AN AUTOPSY. No.
 WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Geo F. Woagner, M. D.

Address Greenville, Mo
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Shiloh Cem. near Shook Mo Aug 25 19 29

20. UNDERTAKER ADDRESS



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