

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 1—Original

ORIGINAL

STANDARD CERTIFICATE OF DEATH

State Department of Health
Division of Vital Statistics
STATE OF IOWA

1 PLACE OF DEATH

County

Township

City

State

or Village

Registered No.

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2 FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If less than
1 day, hrs.
or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

13. NAME

14. BIRTHPLACE (city or town) (State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. LICENSED EMBALMER (Address)

20. FILED

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year)

22. I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1927 to May 12, 1929

I last saw him alive on May 12, 1929 death is said to have occurred on the date stated above, at 11 a.m.

The principal cause of death and related causes of importance in order of onset were as follows:

Date of onset

Apoplexy (probable)
82 A
82 D

Contributory causes of importance not related to principal cause:

He had a hemiplegia some 2 yrs ago

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased

If so, specify

(Signed)

(Address)

M. D.

(OVER)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIANS.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY LICENSED EMBALMERS.

Has decedent ever served in military or naval service of the U.S.? no If so give name of War _____

I, T. S. Plender Licensed Embalmer No. 727 hereby certify that
the body recorded on the reverse side of this certificate was embalmed by T. S. Plender L. E.

No. _____ or by _____ Registered apprentice No. _____
working under my personal supervision.

Signed T. S. Plender

Licensed Embalmer No. _____

NOTE: The above statement MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING.
(Failure to comply with the above constitutes grounds for revocation of license).

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County North
Township Smith
City Smith (No.)

Registration District No. 903
Primary Registration District No. 6211

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. John Triggs Ward.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 2/10/30 John Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 1929

17. I HEREBY CERTIFY, That I attended deceased from to
that I last saw h. else on 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

19

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated in FULL. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

4525