

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

Do not use this space.

7136

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **100**) **St. Baptist Hospital** (Ward)

File No. **2008**
Registered No. **2008**
St. _____ Ward)

2. FULL NAME

William C. Ward
(a) Residence. No. **611 Russell Blvd.** St. **23** Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 3 1864**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 8 21

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

9. BIRTHPLACE (CITY OR TOWN) **Indo**
(STATE OR COUNTRY)

10. NAME OF FATHER **Chas M. Ward**

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

12. MAIDEN NAME OF MOTHER **Emma B Smith**

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

14. INFORMANT **Gertrude L. Ward**
(Address) **1636 S Theresa ave**

15. FILED **Mar C. Standley**
19 **70** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Febry 24 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 16** 1930, to **Feb. 24** 1930, and that I last saw him alive on **Feb. 24** 1930, and that death occurred, on the date stated above, at **9:40 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy (rt. side paralyzed)
Cerebral Hemorrhage (Apoplectic)
Hemiplegia
(duration) **8** yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Arterio-sclerosis and Hypertension**
(duration) **?** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH **609 Russel**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **Charles H. Shewin**, M. D.

Indo, 1930 (Address) **3720 Washington**

*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 **Valhalla** DATE OF BURIAL **Febry 26 1930**

20. UNDERTAKER **Blumenthal & Co. Grand Blvd** ADDRESS **2217**

N. B.—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.

246
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