

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

Do not use this space.

21440A

1. PLACE OF DEATH
 County Jackson Registration District No.
 Township Ray Primary Registration District No.
 City Kansas City (No.) St. Ward (.....)

2. FULL NAME Ward - Albert Bert
 (a) Residence. No. 1124 Harrison St. 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. 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) Mrs Cecile Hannah Ward

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 14 - 1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	43	9	25	

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

9. BIRTHPLACE (CITY OR TOWN) Sandusky
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER John Ward

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Cecile H. Ward
 (Address) 1124 Harrison Kansas City Mo

15. FILED..... 19..... REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1931

17. I HEREBY CERTIFY, That I attended deceased from 6-7 1931 to 6-9 1931 that I last saw him alive on 6-9 1931 and that death occurred, on the date stated above, at 6:03 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
with Uremia
131
1328 (duration) yrs..... mos..... ds.

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

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) P. C. Williams M. D.
 , 19 (Address) Sup K.C. General Hospital

*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 <u>Maple Hill Cemetery</u>	DATE OF BURIAL <u>6-11</u> 19 <u>31</u>
20. UNDERTAKER <u>John J. Sheehan</u>	ADDRESS <u>K.C. Mo</u>

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.

MISSOURI STATE BOARD OF HEALTH - THIS IS A PERMANENT RECORD

