

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

Do not use this space.

**1. PLACE OF DEATH**

County St. Francois  
 Township St. Francois

Registration District No. 773  
 Primary Registration District No. 6018A

File No. 38751  
 Registered No. 145  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

Near Farmington, Mo. (No. \_\_\_\_\_)

**2. FULL NAME** Jennie Ward

(a) Residence. No. St. Louis 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
45 ? ?

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY)

**PARENTS**  
 10. NAME OF FATHER Unknown  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 12. MAIDEN NAME OF MOTHER Unknown  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Hospital Records  
 (Address) Farmington, Mo.

15. FILED 11-9-31 B. L. Robinson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 7 1931

17. I HEREBY CERTIFY, That I attended deceased from 7-14 1931, to 11-7 1931, that I last saw him alive on 11-7 1931, and that death occurred, on the date stated above, at 10:20 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

pulmonary tubercul-  
osis  
23H  
8 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) epilepsy

(duration) yrs. mos. ds.

**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) Frank Long M. D.

11-9-31 (Address) Farmington 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 Hospital Cemetery DATE OF BURIAL 11-9 1931

20. UNDERTAKER Hospital No 4 ADDRESS Farmington Mo

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.

DEC 26 1931

MRS. HARRY E. YORGER  
3928 EAST 11TH STREET  
INDIANAPOLIS, INDIANA

Nov. 29, 1931

My Dear Sir:-

In regards to a small  
insurance policy that insured  
Oliva J. Ward. And the Death  
Certificate shows Jennie Ward.  
The insurance company requests  
that you change the Certificate  
to read, OLIVA, J. Ward, before  
they can pay the claim.  
Kindly state if there is any  
further charge. And Oblige  
Mrs. Yarger.

**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..... Registration District No..... File No.....  
Township..... Primary Registration District No..... Registered No.....  
City..... (No.....) St..... Ward.....

**2. FULL NAME**

*Oliva Jennie Ward*

(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**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 or (or) WIFE of.....

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

7. AGE YRS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)s..... (duration) yrs. mos. ds.  
(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 *Myrtle Emily Yeager*  
(Address) *3928 E 11<sup>th</sup> St. Indianapolis*

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

**MEDICAL CERTIFICATE OF DEATH**

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

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 19.....

20. UNDERTAKER ADDRESS

REPRODUCED BY LAW

SUPPLEMENTARY