

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

Do not use this space.

32888

File No. _____
Registered No. 15
St. _____ Ward _____

1. PLACE OF DEATH

45 County Howard Registration District No. 380
3 Township _____ Primary Registration District No. 4224
1 City Franklin (No. _____)

2. FULL NAME Robert Allen 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 Male 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) 2-13-33
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 21

OCCUPATION
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) Franklin (STATE OR COUNTRY) Mo.

MOTHER FATHER
13. NAME Allen National Ward

14. BIRTHPLACE (CITY OR TOWN) Howard Co. (STATE OR COUNTRY)

15. MAIDEN NAME Elmira H. Hamaker

16. BIRTHPLACE (CITY OR TOWN) Charadon Co. (STATE OR COUNTRY)

17. INFORMANT Mrs. A. W. Ward (ADDRESS) Franklin, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Beards Chapel DATE 10/6/33 19

19. UNDERTAKER L. S. Duncanson (ADDRESS) New Franklin, Mo.

20. FILED 10-5- 1933 J. B. Coe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4, 1933
22. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1933 to Oct 3, 1933
I last saw him alive on Oct 2, 1933 Death is said to have occurred on the date stated above, at 9:45 a.m.
The principal cause of death and related causes of importance were as follows:

Tuberculosis meningitis Date of onset Sept 15-33
malnutrition

Name of operation _____ Date of _____
What test confirmed diagnosis? Spinal fluid 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? no
If so, specify _____
(Signed) L. S. Duncanson, M. D.
(Address) New Franklin, 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.

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