DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28019

REC'D SEP 14 1939

Registration District No. 791 Primary Registration District No. _____ Registrar's No. 7519

1. PLACE OF DEATH: 1003

(a) County 1

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis, 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4630 S. Main
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Ward 630

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ?? ?? unknown

6. (c) Age of husband or wife if alive ?? years

7. Birth date of deceased ?? unknown (Month) (Day) (Year)

8. AGE: Years 85 yrs. Months Days If less than one day _____ hr. _____ min.

9. Birthplace New York (City, town, or county) 1 (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

FATHER
12. Name Thomas Ward
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ann Morrison
(b) Address City Hospital, #18

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 8-9-39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Rutter
(b) Address 3500 Rutger

19. (a) AUG 31 1939 (Date received local registrar) (b) J. F. Buddeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1939 hour 11:30 minute P M.

21. I hereby certify that I attended the deceased from 7/20/39 _____, 19__, to 7/22, 1939 that I last saw him alive on 7/22, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration c̄ Decompensation

Due to

Due to

Other conditions Prostatic cerebrum
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1 (Specify type of place)
While at work? (e) Means of injury

23. Signature Wm Piper (M. D. or other)
Address City Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 I X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.