

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.

Registration District No. 400

Primary Registration District No. 555310

State File No. _____

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Jackson County Home for the Aged
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 years
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Little Blue
(If outside city or town limits, write "RURAL")
 (d) Street No. J. C. Home
(If rural, give location)
 (e) If foreign born, how long in U. S. A. all his life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
 year 1940 hour 11 minute 2 A. M.

21. I hereby certify that I attended the deceased from 4-15, 1940 to 5-2, 1940
 that I last saw him alive on 5-2, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
 Duration _____

Due to _____
 Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? at home
 (e) While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
 Address [Address] Date signed 5-2-40

3. (a) PRINT FULL NAME Walter Ladd 3rd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 8 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace New Hampshire _____
(City, town, or county) (State or foreign country)

10. Usual occupation Call Salesman _____

11. Industry or business _____

12. Name Walter Ladd

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
 (b) Address 70 County Home

17. (a) Burial (b) Date thereof May 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director [Signature]
 (b) Address _____

19. (a) 5-2-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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.....

Wm L Ward

Licensed Embalmer No. *3991*

P. O. Address. *5725 Virginia*

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.