. No. 2
-4-13-40
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 16 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27956

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 853

1. PLACE OF DEATH
(a) County: BUCHANAN
(b) City or town: ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 mo. 8 days (Specify whether years, months or days)
In this community: 30-or-40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St Joseph (If outside city or town limits, write "RURAL")
(d) Street No.: 1312 N 4th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Florence Ward 630
3. (b) If veteran, name war: ____
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Albert Ward
6. (c) Age of husband or wife if alive: ? years
7. Birth date of deceased: June (Month) 12 (Day) 1877 (Year)

8. AGE: Years	Months	Days	If less than one day
63	1	22	hr. ____ min.

9. Birthplace: Richmond (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____
MOTHER FATHER
12. Name: Green Smith
13. Birthplace: Richmond (City, town, or county) Mo (State or foreign country)
14. Maiden name: Malinda Dodson
15. Birthplace: Richmon (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Records State Hosp # 2
(b) Address: St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-7-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland
18. (a) Signature of funeral director: Graves Funeral Home
(b) Address: 806 - S. 17th
19. (a) Aug 7 1940 (Date received local registrar) (b) H J Reitlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 4 year: 1940 hour: 2 minute: 10 P.M.
21. I hereby certify that I attended the deceased from June 26, 1940 to August 4, 1940 that I last saw her alive on August 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Congestion of lungs — Duration: ~~one wk~~ 7-31-40
Due to: Arteriosclerotic Heart Disease
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: no operation
Of autopsy: no 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): none
(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? —
While at work? (Specify type of place) (e) Means of injury: —
23. Signature: D S Johnson (M. D. or other) M. D.
Address: State Hosp #2 St Joseph, Mo. Date signed: 8-4-40

(Licensed Embalmer's Statement on Reverse Side)

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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed A. H. Moore

Licensed Embalmer No. 948

P. O. Address St. Joseph

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

If this body is not embalmed, fact should be so stated above.