DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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FILED OCT 13 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29872

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 870

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

1. PLACE OF DEATH:
(a) County Buchanan,
(b) City or town Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day, (Specify whether
In this community 20 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri, (b) County Buchanan
(c) City or town Saint Joseph,
(If outside city or town limits, write "RURAL")
(d) Street No. 3516 Lafayette Street,
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Frances Ward,
3. (b) If veteran, name war None,
3. (c) Social Security No. None,

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married,
6. (b) Name of husband or wife Jacob Henry Ward,
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased January 24, 1871 (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 16 If less than one day hr. min.

9. Birthplace Richardson County, Nebraska (City, town, or county) (State or foreign country)
10. Usual occupation At Home,
11. Industry or business
MOTHER FATHER
12. Name James Jasper Garner,
13. Birthplace Ray County, Missouri, (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 Jacob H. Ward
(b) Address 3516 Lafayette Street,
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/12/42 (Month) (Day) (Year)
(c) Place: burial or cremation Hamburg, Iowa,
Heaton-Wade-Bowman-Turner
18. (a) Signature of funeral director
(b) Address 319 So. 10th Street, Hm
19. (a) 9-12-42 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10th. year 1942 hour 6:00 minute 45 a.m.
21. I hereby certify that I attended the deceased from July 22, 1942 to Sept. 10, 1942 that I last saw h. alive on Sept. 9, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	
Due to	
Due to	
Other conditions Nontoxic Cardiomegaly (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?
While at work? (Specify type of place) (e) Means of injury
23. Signature C. E. Bryson (M.D.)
Address St Joseph Mo Date signed 9-10-42

12.93 (Licensed Embalmer's Statement on Reverse Side)

N
1
3
W
1
5
1

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~~ Sept. 10, 19

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

working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 3907

P. O. Address 319 So 10th St Joseph Mo

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, fact should be so stated above.

No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29872

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 670

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Sarah Frances Ward
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan (Month) 24 (Day) 1871 (Year)
8. AGE: Years 71 Months Days If less than one day hr. min.
9. Birthplace: Neb. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 24 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	
Due to: Arteriosclerosis	
Due to: Pertus Carcinoma	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: HBP	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature: Guy E. Bingham (M. D. or other)
Address: Sept. 24 1942 Date signed
210 Mitchell Bldg.

SUPPLEMENTARY