

S. No. 2  
M-5-42  
v. 5-17-39  
9-1 X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39452

State File No. \_\_\_\_\_

FILED JAN - 5 1943 18

Registrar's No. 10674

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
Firman Desloge Hosp. O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. L. 96

(c) City or town Webster Groves "NR."  
(If outside city or town limits, write "RURAL")

(d) Street No. 245 Jola Dr  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ward, Elmer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Cletus

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Oct. 3rd 1895  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>2</u>	<u>16</u>	_____ hr. _____ min.

9. Birthplace Licking Mo. (City, town, or county) (State or foreign country) O

10. Usual occupation Pipe Fitter

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Mart Ward

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

14. Maiden name Julia Reid

15. Birthplace Licking Mo. (City, town, or county) (State or foreign country) D

16. (a) Informant Cletus Ward

(b) Address 245 Jola Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-42  
(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 22 1942 (Date received local registrar) (b) J. H. Bredsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1942 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from 12-12-42 to 12-19-42 1942 and that death occurred on the date and hour stated above

Immediate cause of death Edema of Brain

Due to Craniotomy and Removal of Brain Tumor 24 hours

Due to Brain tumor - Rt Temporal lobe

Other conditions Unobtain  
(Include pregnancy within 3 months of death)

Major findings: Brain Tumor

Of operations Autopsy as to cause of death

Of autopsy Not granted malignancy

Underline the cause to which death is 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) (a) Means of injury \_\_\_\_\_

23. Signature Louis J. Moore (M. D. or other) Desloge Hosp. Date signed \_\_\_\_\_

12-19-42

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

106712  
172907

106712  
172907

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**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, fact should be so stated above.**