

10073

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED NOV 10 1944

Registration District No. 141

Primary Registration District No. 3075

Registrar's No. 90

1. PLACE OF DEATH:

(a) County HOWELL  
(b) City or town WEST PLAINS, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
10A WORCESTER  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No. (Specify whether  
In this community 38 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL 46  
(c) City or town WEST PLAINS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 10A WORCESTER  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES STEWART WARD

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

4. Sex MALE 0 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife VIRGINIA STRAIN WARD 6. (c) Age of husband or wife if alive 77 years  
7. Birth date of deceased FEBRUARY 8, 1863  
(Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace FROSTBURG, MARYLAND  
(City, town, or county) (State or foreign country)

10. Usual occupation LEATHER GOODS MFG.

11. Industry or business OWN ESTABLISHMENT

MOTHER FATHER { 12. Name WM. WARD,  
13. Birthplace VA. (State or foreign country)  
14. Maiden name EMILY RUTH STEWART  
15. Birthplace VA. (State or foreign country)

16. (a) Informant MRS. C.S. WARD  
(b) Address WEST PLAINS, Mo.

17. (a) BURIAL (b) Date thereof OCT. 23, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation OAK LAWN CEM. W. PLAINS, Mo.

18. (a) Signature of funeral director Hals Stoumberg  
(b) Address WEST PLAINS, Mo.

19. (a) 10-44 (b) [Signature]  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20  
year 1944 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from  
October 19, 1944 to October 20, 1944;  
that I last saw him alive on October 20, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis Duration \_\_\_\_\_

Due to Coronary Arteriosclerosis  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations gua 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) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address West Plains, Mo. Designated 44

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

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RECEIVED

District Health Officer No. 5,

District File Number 1144549

Date Filed 11-8-74

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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 Hal Thomburg

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.**