

Registration District No. 229

Primary Registration District No. 5825

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Corning
(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) 1

(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 New Madrid

(c) City or town Parma No. 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 1

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Charles Ward

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 45 hour 6 minute 40 P. M.

I hereby certify that I attended the deceased from June 1944
April 20 1945 to _____ 19____;
that I last saw him alive on April 20 _____ 19____;
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Zula Ward 6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased March 21 1870
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage

8. AGE: Years 75 Months 30 Days _____ If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace Shroville MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Gardner

11. Industry or business Retired Gardner

MOTHER FATHER { 12. Name Anderson Ward

13. Birthplace Shroville MO 0
(City, town, or county) (State or foreign country)

14. Maiden name Sittie Elizabeth Rushing

15. Birthplace Shroville MO 0
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Zula Ward

(b) Address Parma

17. (a) Burial (b) Date thereof 4/22/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Cemetery

18. (e) Signature of funeral director Watkins Funeral Home

(b) Address Parma

19. (a) 4/21/45 (b) D. Brown
(Date received local registrar) (Registrar's signature)

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 Dr. George H. ... (M. D. or other) MD

Address Parma MO Date signed 4/21/45

RECEIVED

District Health Office No.

District File Number 545-7

Date Filed 5-11-9

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.