

FILED JUL 28 1945 STANDARD CERTIFICATE OF DEATH 1003

State File No. 6185

Registration District No. Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 mos. 4 days  
In this community Life  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 090 y V  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2113a Papin  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME James Ollie Ward

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 2 5. Color or race negro 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased 10 27 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
8 17 hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

12. Name Robert Ward

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

14. Maiden name Muirelle

15. Birthplace Tenn. /  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Ward

(b) Address 2113a Papin St.

17. (a) Shipped (b) Date thereof 7 / 17 / 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland, Tenn.

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address 215 So. Jefferson Ave.  
19. (a) JUL 17 1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14,  
year 1945 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from May 10, 1945, to July 14, 1945,  
that I last saw h. im alive on July 14, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Diarrhea  
Active Rickets with tetany

Duration  
14 days  
2 mos.

Due to.....

Due to.....

Other conditions (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 R. E. Coyle (M. Death) Address 26217 W. 1st St. Date signed 7/16/45

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

**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. *2698*

P. O. Address *2769 Chouteau*

**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.**