

**FILED MAR 10 1947**

Registration District No. 187

Primary Registration District No. 4302

Registrar's No. 04

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

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

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

In this community Lifetime  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston <sup>59</sup>

(c) City or town Chula <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) <sup>0</sup>

(e) Citizen of foreign country? No (Yes or No) <sup>0</sup>  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James William Ward

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9  
year 1947 hour 1 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb. 2 - 47  
47 to Feb. 9 - 47 1947  
that I last saw him alive on Feb. 9 - 47 1947  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife Carrie Burns Ward

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased: September 1 1864  
(Month) (Day) (Year)

Immediate cause of death: Cardiac Decompensation, Senility

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: ASC  
Of operations \_\_\_\_\_

Of autopsy none

Duration 3 1/2 hrs

19 yr

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years 82 Months 5 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Livingston Co. Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

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

12. Name John William Ward

13. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Elizabeth Austin

15. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie Ward

(b) Address 6 Kula St

17. (a) Burial (b) Date thereof Feb 13 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plainsview Cemetery

18. (a) Signature of funeral director E. Robertson Funeral Home

(b) Address Chula Mo.

19. (a) Feb-11-47 (b) Frances B. Nail  
(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) no

(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) (Specify means of injury)

23. Signature Joseph [unclear] (M. D. or other) M.D.  
Address 117 E. [unclear] Chula, Mo. signed Feb 11 - 47

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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 John M Robertson

Licensed Embalmer No. 4388

P. O. Address Jaredo 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.