

FILED MAY 8 1947

Registration District No. **2**

Primary Registration District No. **3052**

1. PLACE OF DEATH:

(a) County **PETTIS**
(b) City or town **SEDALIA**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1302 E 11TH
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **42 yrs.** (Specify whether years, months or days)
In this community **42 yrs.**

3. (a) PRINT FULL NAME **JOHN W WARD**

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 **MARIED**
6. (b) Name of husband or wife **LDA** 6. (c) Age of husband or wife if alive **21** years
7. Birth date of deceased **9-30-1876** (Month) (Day) (Year)

8. AGE: Years **70** Months **7** Days **0** If less than one day hr. _____ min. _____

9. Birthplace **W VA.** (City, town, or county) (State or foreign country)

10. Usual occupation **JANITOR**

11. Industry or business **CHURCH**

12. Name **JOHN WARD**
13. Birthplace **W VA.** (City, town, or county) (State or foreign country)
14. Maiden name **SARA FARNSWORTH**
15. Birthplace **W VA.** (City, town, or county) (State or foreign country)

16. (a) Informant **MRS. J W WARD**
(b) Address **SEDALIA Mo.**

17. (a) **BURIAL** (b) Date thereof **5-2-47** (Month) (Day) (Year)
(c) Place: burial or cremation **CROWN HILL**

18. (a) Signature of funeral director **Geo. Dillard**

(b) Address **Sedalia Mo.**

19. (a) **5-2-47** (b) **Betty Yeager** (Date received local registrar) (Physician's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **PETTIS**
(c) City or town **SEDALIA**
(If outside city or town limits, write "RURAL")
(d) Street No. **1302 E 11th** (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **30** year **1947** hour **10** minute **25 A.**

21. I hereby certify that I attended the deceased from **Apr. 30** to **Apr. 30**, 19**47**, that I last saw him alive on **Apr. 30**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Coronary embolism
Due to **mesenteric thrombosis**

Due to **strangulated hernia**

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

Major findings: Of operations _____

Of autopsy _____

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? **2**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. H. Saunders** (M.D. or other) **D.O.**
Address **501 1/2 R. Englewood, London** Date signed **5-7-47**

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-7-47

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. 3868

P. O. Address Sedalia

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.