

FILED JUN 17 1947

Registration District No.

Primary Registration District No. 3000

Registrar's No. 146

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.O.S. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Baby Boy Ward

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

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

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

7. Birth date of deceased May 29 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 hr. 47 min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Aiva Ward

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

14. Maiden name Laurence Nelson

15. Birthplace Ponahontas Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Ava Ward
(b) Address Bonaparte Id

17. (a) Burial (b) Date thereof 5 30 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonaparte Id

18. (a) Signature of funeral director L. E. Azbell
(b) Address Bonaparte, Iowa
19. (a) 5-30-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County 999
(c) City or town Bonaparte 13
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 29
year 47 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-29
1947, to 5-29 1947
that I last saw him alive on 5-29 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Premature infant below the age of viability
Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)
Major findings: 159
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?
While at work?..... (Specify type of place) (e) Means of injury 2

23. Signature G W Taylor (M. D. or other) DO
Address Kirksville MO Date signed 5-30-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1
3
3

RECEIVED
District Health Officer No. 10
District No. 647-692
JUN 13 1947

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.