

S. No. 2
1-12-45
7-5-17-39
7-1-24-70

26178

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **7011**

FILED AUG 4 1947 318

1003

Registration District No. _____ Primary Registration District 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: **St. Anthony's Hospital** *o*
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5042 Ulena**
15 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Helen Ward**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Earl R. Ward**

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

7. Birth date of deceased **May 6, 1890**
(Month) (Day) (Year)

8. AGE: Years **57** Months **2** Days **19**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Looby**

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

14. Maiden name **Carrie Nartley**

15. Birthplace **Wisconsin**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Earl R. Ward**

(b) Address **5042 Ulena**

17. (a) **Burial** (b) Date thereof **7-29-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director _____

(b) Address **6322 S. Grand, St. Louis, Mo.**

19. (a) **JUL 28 1947** (b) **J. F. Shelton**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25th**
year **1947** hour **11** minute **50** P.M.

21. I hereby certify that I attended the deceased from **7-24** to **7-25**, 19**47**
and that death occurred on the day and hour stated above.

Immediate cause of death **Thrombosis Superior Mesenteric Artery**

Due to **Thrombosis**

Due to _____

Other conditions **Hypertension**
(Include pregnancy within _____ months of death)

Major findings: **Sanguine**
Of operations **enteric septic intussusception**

Of autopsy **none**

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) _____ days of injury

23. Signature **B. J. McFarland** (M. D. or other) _____
Address **3608 B. Grand** Date signed **7-26-47**

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

MOTHER FATHER

Dr. Bryon J. McGinnis,
3608 S. Grand Blvd.,
1 to 3:30 P.M.

2nd Floor
Room 207

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 *J. Wm Bumbley*.....

Licensed Embalmer No. *3653*.....

P. O. Address *St Louis 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..

State File No. Aug
Registrar's No. 7011

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town St Louis
(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)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Helen Ward
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 6
(Month) (Day) (Year)

8. AGE: 57 Years 2 Months 2 Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar)..... (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug Year 1947 hour 12 minute 15 M.
21. I hereby certify that I attended the deceased from 1947 to 1947;
that I last saw him alive on Aug 14, 1947,
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

SEP 2 1947 AUG 14 1947

5-26198

6/10-208