

S. No. 300  
DM-10-47  
Rev. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **39443**

FILED DEC 27 1948  
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1354

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether)

In this community Lifetime  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 1603 Boyd Street  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Richard Harvey Ward

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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: August 7 1948  
(Month) (Day) (Year)

8. AGE: Years 00 Months 4 Days 8  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation infant

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

MOTHER FATHER { 12. Name Clarence E. Ward

13. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Charlene Blair

15. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence E. Ward

(b) Address 1603 Boyd St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof Dec. 17, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Halter Meierhoffer

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) Dec 20, 1948 (b) L. B. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15th  
year 1948 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from 12-13, 1948 to 12-15, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho, pneumonia Duration 3 days

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

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

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

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

Of autopsy 107

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?  
(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Wm. B. Rostman M.D. or other MD  
Address 510 Carby Bldg Date signed 12-15-48

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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 *Albert E. Harrington*  
Licensed Embalmer No. *3258* Missouri  
P. O. Address *St. Joseph, 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.**