

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14257

FILED APR 21 1949

State File No. _____
Registrar's No. **3265**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Neosho		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place) 14	c. CITY (If outside corporate limits, write RURAL and give township) Chanute		
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital			d. STREET ADDRESS (If rural, give location) 401 West Main Street		
3. NAME OF DECEASED (Type or Print) a. (First) Laura		b. (Middle) McFadden	c. (Last) Ward	4. DATE OF DEATH (Month) (Day) (Year) April 10 49	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 26, 1887	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Cashier	10b. KIND OF BUSINESS OR INDUSTRY Banking	11. BIRTHPLACE (State or foreign country) Fredonia, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Gustav McFadden		13b. MOTHER'S MAIDEN NAME Julia Marie Hyde	14. NAME OF HUSBAND OR WIFE Jesse E. Ward		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS A. A. McFadden - 470 Marion			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardiovascular disease with compensation				INTERVAL BETWEEN ONSET AND DEATH sev yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
	DUE TO (b) _____				
	DUE TO (c) _____				
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 9, 1949 , to April 10, 1949 , that I last saw the deceased alive on April 10, 1949 , and that death occurred at 11:03 Pm. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) H. Bradley MD		23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 4/11/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-11-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Chanute, Kansas		
DATE REC'D BY LOCAL REG. APR 11 1949	REGISTRAR'S SIGNATURE J. B. Lassater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. H. Hoppe Inc. 4700 Washington St. Louis Mo.			

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 me

Student Embalmer No.

working under my personal supervision.

Signed Guy W Wilkins

Signed
Student Embalmer

Licensed Embalmer No. 3575

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.