

FILED OCT 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34868

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 340

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Farmington</u> OR TOWN <u>RURAL St. Francois</u>	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>		d. STREET ADDRESS (If rural, give location) <u>2044 No. Broadway</u>	

3. NAME OF DECEASED a. (First) <u>EFFIE</u> (Type or Print)			b. (Middle) <u>VIOLA</u>		c. (Last) <u>WARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 17, 1949</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 18, 1873</u>		9. AGE (in years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Josiah Armstrong Stone</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Eveline Malone</u>		14. NAME OF HUSBAND OR WIFE <u>Edward William Ward</u>	
---	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records State Hospital No. 4, Farmington, Mo.</u>		
---	---	---	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>3 das.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar pneumonia, bilateral</u>	ANTECEDENT CAUSES DUE TO (b) <u>Senility</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>				<u>190X</u>
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 August 15, 1949, to Sept. 17, 1949, that I last saw the deceased alive on Sept. 17, 1949, and that death occurred at 5:45^P m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>John A. Brenner, M.D.</u>	23b. ADDRESS <u>State Hospital No. 4, Farmington Mo.</u>		23c. DATE SIGNED <u>Mo. 9-20-49</u>
--	---	--	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 20, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>RFD #1, Springfield, Mo.</u>	
--	------------------------------------	--	--	--

DATE REC'D BY LOCAL REG. <u>Sept 20, 1949</u>	REGISTRAR'S SIGNATURE <u>Esther Rudolph</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Klinger Funeral Home, Springfield, Mo.</u>	
--	--	--	---	--

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

RECEIVED 10-18-49

District Health Officer No. 4

District File Number 1049-1371

Date Filed _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Paul A. DeGuzal

Licensed Embalmer No. 4120

P. O. Address Larney Lane New

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.