

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **6946**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1204**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3227 Hickory St.		d. STREET ADDRESS (If rural, give location) 18 3227 Hickory St.	
3. NAME OF DECEASED (Type or Print) a. (First) Fannie b. (Middle) Ward c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Feb. 4 1954	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 5, 1896
9. AGE (In years last birthday) 57		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Miss.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
13c. NAME OF HUSBAND OR WIFE Gater Ward		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Robert Ward		ADDRESS 3227 Hickory St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: Hypertension Cardiovascular Disease		DUE TO (b)		?
ANTECEDENT CAUSES		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS				
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? 443x	

22. I hereby certify that I attended the deceased from **1/4**, 1954 to **2/4**, 1954 that I last saw the deceased alive on **1/3**, 1954 and that death occurred at **3 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 3136 Chouteau		23c. DATE SIGNED 2/12	
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24a. BURIAL CREMATION REMOVAL (Specify) Buried		24b. DATE Feb 8 1954		24c. NAME OF CEMETERY OR CREMATORY St. Louis	
24d. LOCATION (City, town, or county) (State) St. Louis County		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE [Signature]		24e. TOWN CLERK'S SIGNATURE [Signature] ADDRESS 2769 Chouteau	

(Licensed Embalmers' Statement on Reverse Side)

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

Case No. 1003

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 *J. J. Watson*
Licensed Embalmer No. *2698*
P. O. Address *2769 Chouteau*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.