

I & R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007409

FILED VS FEB 24 1960

242

4364

5

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stella Mo.		Length of stay in 1b 4 days	c. CITY OR TOWN Granby Mo Rrt. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardwell Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last Ward			4. DATE OF DEATH Month Jan. Day 10 Year 1960		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1892	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Virginia	12. CITIZEN OF WHAT COUNTRY USA
--	---	---	---

13a. FATHER'S NAME Leslie Ward	13b. MOTHER'S MAIDEN NAME Sarah Brown	14. NAME OF HUSBAND OR WIFE Sarah Garber Ward
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Doshia Marion, Stark City Mo Rt
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 week
IMMEDIATE CAUSE (a) Asymptomatic Pneumonia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Influenza (virus)		
DUE TO (c) General debility - chronic myocardial		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from **Jan 8, 60** to **Jan 10 60** and last saw him alive on **Jan 10, 60**
Death occurred at **2:35 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE D.D. Fountain D.D.	(Degree or title)	22b. ADDRESS Wool, Mo.	22c. DATE SIGNED Jan 13/60
---	-------------------	----------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/14/1960	23c. NAME OF CEMETERY OR CREMATORY Macedonia Cemetery	23d. LOCATION (City, town, or county) (State) Stella Missouri
--	-------------------------------	---	---

24. FUNERAL DIRECTOR W. Morris Pope	ADDRESS Wheaton, Mo.	25. DATE RECD. BY LOCAL REG. 1-17-60	26. REGISTRAR'S SIGNATURE Mered Moberly
---	--------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James Kenneth Duncan

Licensed Embalmer No. 4767

P. O. Address Wheaton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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