

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031201

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7165

STATE FILE NUMBER

FILED AUG 23 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in lb		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1039a Goodfellow Ave.,</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1039a Goodfellow Ave.,</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle Last <u>Ward Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-61</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>h</u> Days <u>h</u> Hours <u>h</u> Min. <u>h</u>		IF UNDER 24 HR Hours <u>h</u> Min. <u>h</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Clayton Ward Sr.</u>			13b. MOTHER'S MAIDEN NAME <u>Carol Black</u>			14. NAME OF HUSBAND OR WIFE <u>-</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>None</u>		17. INFORMANT <u>Carol Ward</u> Address <u>1039a Goodfellow Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abletosis</u> DUE TO (b) <u>762.0</u> DUE TO (c) <u>762.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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 <u>10:45</u> Month, Day, Year <u>8-2-61</u> a.m. p.m.		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 <u>10:45</u> To <u>11:00</u> and last saw her/him alive on <u>8/2/61</u> Death occurred at <u>10:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul J. Simon Deputy coroner</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>8/2/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8-2-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u> ADDRESS <u>4202 Finney Ave.,</u>				25. DATE RECD. BY LOCAL REG. <u>AUG 2 1961</u>		26. REGISTRAR'S SIGNATURE <u>Heart Smith, M.D.</u>	

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward P. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.,

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.