

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045497

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3043

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> Length of stay in 1b <u>3 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7005 Southland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
--	--	--	--

3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul R. WARD</u>			4. DATE OF DEATH Month Day Year <u>October 20, 1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-03</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Utility</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>		11. BIRTHPLACE (City and state or country) <u>Covington, Ky.</u>		
13a. FATHER'S NAME <u>David Ward (Dec)</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown (Dec)</u>		14. NAME OF HUSBAND OR WIFE <u>Marie 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.		17. INFORMANT <u>Mrs. Marie Ward, 7005 Southland</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>Pneumonitis, Rt.</u> DUE TO (b) <u>Metastatic Ca of Both Hiluses</u> DUE TO (c) <u>Carcinoma Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/22/62</u> <u>to mos.</u> <u>5 yrs</u>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Acute Myocardial Decomensation</u>		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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 3/2/60 Intermittent to Oct. 20, 1962 and last saw him alive on Oct. 20, 1962 7-AM
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Chakada, MD</u>	22b. ADDRESS <u>Medical West Blvd, Covington 5</u>	22c. DATE SIGNED <u>10/22/62</u>
---	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 23, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>
---	--	---	--

24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>	ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>10-22-62</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
--	--------------------------------------	--	--

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
14003
2' 202
3
4 0
5 1
6
7 1
8 2
9153.8
10
11
12 44-0
13

Dr. Nakada
950 Francis Place
Pa 1-8890

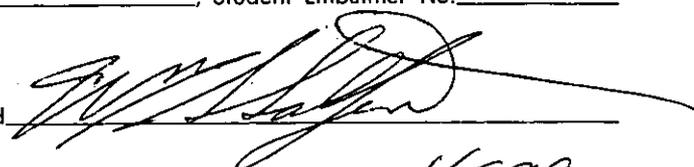
STATEMENT BY LICENSED EMBALMER

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 _____



Licensed Embalmer No. 4699

P. O. Address 3840 Judd

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.