

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 317)

Registration District No. 547
Primary Registration District No. 3029
Barker St.

File No. 9681
Registered No. 87
St. 2nd Ward

FULL NAME

Willis Ware
317 Barker St.

(a) Residence, No. 317 Barker St., Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
about 58

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

13. NAME Willis Ware

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

15. MAIDEN NAME No record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Ellen Smith
2 Meyer Place

18. BURIAL, CREMATION, OR REMOVAL PLACE Robinson DATE 3-16 1934

19. UNDERTAKER (ADDRESS) Geo. E. Roberts
Hannibal, MO

20. FILED Mo. 20, 1934 W. H. Webster Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-14, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 11 a.m.

The principal cause of death and related causes of importance were as follows:

apoplexy
g.g.a.
Date of onset

Other contributory causes of importance:

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? Hannibal, Marion Co., Mo
(Specify city of town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury fell over while installing

Nature of injury & died without medical attention

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Carl E. Klump _____

(Address) Hannibal, MO
Corner, Marion Co., Mo.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion
Township Hannibal
City Hannibal (No.)

Registration District No. 547
Primary Registration District No. 3029

File No.
Registered No.
St. Ward)

2. FULL NAME Willis Ware

(a) Residence, No. St., Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER Geo E. Roberts (ADDRESS)

20. FILE 1934 E. M. Lucas Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 14, 1934

22. I HEREBY CERTIFY, That I attended deceased from

10....., to....., 19..... I last saw him alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death, and related causes of importance were as follows:

apoplexy
cerebral apoplexy
Other contributory causes of importance: 82a1

Date of onset

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Cecil Lee, M. D.

(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT REC. IVI SEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-9684

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