

REC'D FEB 20 1939

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

1188
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Kan Primary Registration District No. 1002 Registered No. 261
(c) City W. G. Mo. (d) Street No. General Hospital #2 St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

657 Elizabeth Ware
(a) Residence, No. 25 180 Harrison St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-23-1919
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 6 17
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as 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 Deceased
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
15. MAIDEN NAME Deceased
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
17. INFORMANT (NAME) (ADDRESS) Record Clerk
General Hospital
18. BURIAL, CREMATION, OR REMOVAL PLACE Odessa Mo. DATE Dec. 11 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) M. L. Hicks
Lyndon Mo.
20. FILED Jan 16, 1939 W. G. Mo.
W. G. Mo.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-6 1938
22. I HEREBY CERTIFY, That I attended deceased from 12-3 1938 to 12-6 1938
I last saw her alive on 12-6 1938 Death is said to have occurred on the date stated above, at 3:45 pm.
The principal cause of death and related causes of importance were as follows:
Preperal
Sepsis
Date of onset _____
Other contributory causes of importance: 1450
Name of operation _____ 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? _____ (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) J. O. Gentry
(Address) General Hospital #2

MAR 24 1948

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 *W. M. Denton*

Registered Apprentice No. *147*, working under my personal supervision.

Signed *Mrs Fannie L. Meek*

Licensed Embalmer No. *3818*

P. O. Address *1705 E 18 St. K.C.*

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

If this body is not embalmed, above space should be left blank.