

Registration District No. 2410

Primary Registration District No. 4273

Registrar's No.

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Dover
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: city
(If not in hospital or institution, write street number or location) 7
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

LILLIE JOE ANN WARE HOE

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Fe

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) Feb.

(Day) 18

(Year) 1940

8. AGE:

Years

Months

Days

If less than one day

22

hr.

min.

9. Birthplace

Dover, MO
(City, town, or county)

MO
(State or foreign country)

10. Usual occupation: _____

11. Industry or business _____

MOTHER FATHER

12. Name

Orville Ware

13. Birthplace

Sugar Creek
(City, town, or county)

MO
(State or foreign country)

14. Maiden name

Thasgarat King

15. Birthplace

7 Hodge
(City, town, or county)

MO
(State or foreign country)

16. (a) Informant's own signature

Orville Ware

(b) Address

Dover, MO.

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Mar 11 - 1940
(Month) (Day) (Year)

(c) Place: burial or cremation

Dover, MO

18. (a) Signature of funeral director

Whipple

(b) Address

Lexington, MO

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Lafayette
(c) City or town Dover, MO
(If outside city or town limits, write "RURAL.")
(d) Street No. city
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 10
year 1940 hour 10 minute 25-A. M.

21. I hereby certify that I attended the deceased from Feb. 18
1940, to Mar. 10, 1940;

that I last saw her alive on March 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Streptococcus sore throat

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

413

(Specify type of place)

While at work? _____

(e) Means of injury _____

23. Signature

J. S. Cape

(M. D. or other) MD

Address

Lexington, MO

Date signed

3/11/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS & CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-11-40

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

7. S. 2B
DM-2-21-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11489

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 760

Primary Registration District No. 4273

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Boyer
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Lellie Jo Ann Ware

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 32 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 3-1940 (Date received local registrar) (b) Tiffany Webb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Boyer
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month Mar day 10 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. S. Cape (M. D. or other) _____

Address Lexington _____

SUPPLEMENTAL COPY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11489 (1940)