

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 472

Registration District No. 318 Primary Registration District No. 2001

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution Mary Wilson Home 3  
(d) Length of stay: \_\_\_\_\_  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Greene  
(c) City or town Springfield  
(d) Street No. 924 N. Main  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Dora Fickie Ware  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 26 year 1940 hour 11 minute P M.  
21. I hereby certify that I attended the deceased from 1938, 19\_\_\_\_, to 5/26, 1940 that I last saw him/her alive on 5/26, 1940 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Coleman Ware 6. (c) Age of husband or wife if alive (Deceased) years  
7. Birth date of deceased March 17, 1968

Immediate cause of death Tuberculosis, glandular  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Under conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 1 Months 72 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Commerce, MO

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Inmate of old hodgep home  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name George W. Fickie  
13. Birthplace Unknown Penna.  
14. Maiden name Margaret Harris  
15. Birthplace Unknown Mo.  
16. (a) Informant's own signature Sussie Clark  
(b) Address Mount, Louisiana  
17. (a) Burial (b) Date thereof 5-29-40  
(c) Place: burial or cremation Angelwood  
18. (a) Signature of funeral director Alvin Schreyer  
(b) Address Springfield, Mo.  
19. (a) May 29, 1940 (b) W. P. Handley

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ Means of injury \_\_\_\_\_  
Signature Ray D. Callaway (M. D. or other) MD  
Address Springfield Mo. Date signed 5/27/40

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 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV-5-17-30 1 x 10811

JUL 27 1944

**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 Lewis G. Scherpf

Licensed Embalmer No. 3802

P. O. Address Springfield, Ma.

**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.**

X