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 DM-9-4-41
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 3639
 Registrar's No. _____

FILED MAY 7 1942 791
 Registration District No. _____

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Ferguson
(If outside city or town limits, write "RURAL")
 (d) Street No. Rt. 10 Box 503
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James Aaron Wear
 3. (b) If veteran, name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 22nd.
 year 1942 hour 11.10 minute _____ P. _____ M. _____
 21. I hereby certify that I attended the deceased from 4-11-1942 to 4-22-1942
 that I last saw him alive on 4-22-1942
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife Minnie Wear
 6. (c) Age of husband or wife if alive Decd years
 7. Birth date of deceased July 16th 1865
(Month) (Day) (Year)

Immediate cause of death: Bronchial pneumonia 10 days

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>6</u>	hr. _____ min. _____

Due to Myocarditis 1938
 Due to Myocarditis 1935
 Other conditions Arteriosclerosis 1930
(Include pregnancy within 3 months of death)

9. Birthplace Cole County, Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation Farmer
 11. Industry or business Retired

PHYSICIAN
 Major findings: none
 Of operations _____
 Of autopsy none
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name William Wear
 13. Birthplace Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Meadows
 15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L. Owsley
 (b) Address Ferguson, Mo.
 17. (a) Burial (b) Date thereof 4-25-42
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Valhalla Cemetery
 18. (a) Signature of funeral director Provost Und. Co.
 (b) Address 3710 N. Grand Blvd.
 19. (a) 34 1942 (b) J. R. Brubaker
(Date received local registrar) (Registrar's signature)

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) Means of injury _____
 23. Signature Ray Johnson (M. D. or other) _____
 Address Ferguson Mo. Date signed 4/23/42

R. Johnson
#40 Home and Reg

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 *Robert L. Burkman*

Licensed Embalmer No. *3553*

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, fact should be so stated above.