

FILED JAN 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. **40317**
Registrar's No. **5189**

Registration District No. **149** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution: **General Hospital #2 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **16 days** (Specify whether
In this community **22 years** years, months or days)

3. (a) PRINT FULL NAME **Ophelia Ware**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **495-03-3006**

4. Sex **Female** 5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **John R. Ware**

6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **January 1904**
(Month) (Day) (Year)

8. AGE: Years **41** Months **11** Days **9** If less than one day hr. min.

9. Birthplace **Conway, Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Press Operator**

11. Industry or business **Ideal Laundry**

MOTHER FATHER { 12. Name **Edward Jones**

13. Birthplace **Miss /**
(City, town, or county) (State or foreign country)

14. Maiden name **Florence Gration**

15. Birthplace **Ark. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Medical Records Librarian**

(b) Address **General Hospital #2**

17. (a) **Removal** (b) Date thereof **12-19-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Conway, Ark.**

18. (a) Signature of funeral director **Adrian Brown**

(b) Address **2000 E. 12th**

19. (a) **12-17-45** (b) **Shiraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1800 E. 13th** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **16**, year **1945** hour **3:** minute **49** A. M.

21. I hereby certify that I attended the deceased from **November 20**, 19**45**, to **December 16**, 19**45**;

that I last saw her alive on **December 16**, 19**45**; and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Malignant Hypertension**
Nephrosclerosis

Due to _____

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

Major findings: _____
'Of operations _____

Of autopsy **131a**

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 **[Signature]** (M. D. number) _____

Address **General Hospital #2** Date signed **12/17/45**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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..... *A. T. Moore*.....

..... Licensed Embalmer No. *948*.....

..... 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.