

No. 2
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 5 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **155**
Registrar's No. **24**

Registration District No. **38** Primary Registration District No. **3006**

1. PLACE OF DEATH:
(a) County **Boone**
(b) City or town **Columbia**
(c) Name of hospital or institution: **University Hospitals**
(d) Length of stay: In hospital or institution **3 days**
In this community **11 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Boone**
(c) City or town **Columbia**
(d) Street No. **Niedermeyer Apartments**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Emma Ware**
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
6. (a) Name of husband or wife **H.C. Ware (deceased)**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept. 12, 1883**
8. AGE: Years **64** Months **4** Days **11**

9. Birthplace **Kalamazoo Michigan**

10. Usual occupation **practical nurse**

11. Industry or business _____
12. Name **James G Troxell**
13. Birthplace **UNKNOWN**
14. Maiden name **Eunice T. Hayes**
15. Birthplace **UNKNOWN**

16. (a) Informant **Miss Beulah Ware**
(b) Address **Niedermeyer Apts. Columbia Mo**
17. (a) **Burial** (b) Date thereof **1 26 48**
(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Parlier Funeral Service**
(b) Address **187N 104 St Columbia Mo.**
19. (a) **1-24-48** (b) **Mrs R.E. Palmer**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **23** year **1948** hour **8** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **Nov 12**, 1947 to **Jan 23**, 1948
that I last saw her alive on **Jan 23**, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: **Encephalitis post infectious herpes zoster**

Other conditions: **GOB**
(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? _____
(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]** Address **Columbia** Date signed **1/23/48**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 3 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.....

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

Signed *Thas L. Haring*

Licensed Embalmer No. *4132*

P. O. Address *Columbia, Mo*

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.