

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18660**
Registrar's No. **4284**

BIRTH NO. _____ REG. DIST., NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2024 Carr St.		d. STREET ADDRESS (If rural, give location) 2024 Carr St.	

3. NAME OF DECEASED (Type or Print) a. (First) Mattie b. (Middle) c. (Last) Ware			4. DATE OF DEATH (Month) (Day) (Year) May 4 1952		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow Divorced	8. DATE OF BIRTH SEPT. 28, 1855	9. AGE (In years last birthday) 96	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Jackson Ware		13b. MOTHER'S MAIDEN NAME Hannah Bike		14. NAME OF HUSBAND OR WIFE (Divorced) Alice Harris (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Reuben Ware ADDRESS 2024 Carr	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral accident		INTERVAL BETWEEN ONSET AND DEATH 7 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerotic Heart Disease (?)		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <input checked="" type="checkbox"/>			

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H2DV

22. I hereby certify that I attended the deceased from **4-30-1952** to **5-4-1952**, that I last saw the deceased alive on **5-3-1952**, and that death occurred at **1 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. J. Smith	23b. ADDRESS 450-7 N. E. 1st	23c. DATE SIGNED 5-7-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 10, 1952	24c. NAME OF CEMETERY OR CREMATORY Washington Park
		24d. LOCATION (City, town, or county) (State) St. Louis County

DATE REC'D BY LOCAL REG. MAY 7 1952	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Lane ADDRESS 2217 Grand
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

Clarence Crooks

Licensed Embalmer No. *47555*

P. O. Address *122111*

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.