

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003609

STATE FILE NUMBER

245

JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

Health,  
Welfare  
Public  
Service

300

-57

71

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Length of stay in 1b <b>25 yrs.</b>	d. STREET ADDRESS <b>4165 Blaine</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Monroe</b> Last <b>Ware</b>			4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1959</b>		
5. SEX <b>Male</b> <input type="checkbox"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1894</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	11. BIRTHPLACE (City and state or country) <b>Owensboro, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>William Wade Ware</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Vargason</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Ware</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>402-10-3976</b>	17. INFORMANT Address <b>Anna Ware, 4165 Blaine Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>HEMOLYTIC ANEMIA</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>1-1-59</b> to <b>1-8-59</b> and last saw her/him alive on <b>1-7-59</b> Death occurred at <b>2:45</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Elizabeth A. Stoddard M.D.</b>			22b. ADDRESS <b>Jewish Hospital</b>		22c. DATE SIGNED <b>1-8-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-10-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>JAN 8 59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *G. W. Wilkinson* .....

Licensed Embalmer No. *3574* .....

P. O. Address *N. La* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.