

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017418

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 539

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) 914 E. Brower		d. STREET ADDRESS (If outside, give location) 914 E. Brower	

3. NAME OF DECEASED (Type or print) First Floyd Middle Harland Last Ware			4. DATE OF DEATH Month May Day 31 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1895	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jordan Ware	13b. MOTHER'S MAIDEN NAME Isabell^e Burton	14. NAME OF HUSBAND OR WIFE Nellie C. Ware
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 500-01-2401	17. INFORMANT Mrs. Nellie C. Ware	Address Springfield, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMATIC HEART DISEASE, INACTIVE		INTERVAL BETWEEN ONSET AND DEATH NATY YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 416X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour _____ 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 Springfield	COUNTY Greene	STATE Mo.
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21. I attended the deceased from 11-13-57 to 5/31/59 and last saw her/him live on 5/31/59 Death occurred at 7:15 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John O. T. Ware, M.D.	(Degree or title) 0	22b. ADDRESS 609 Cherry Springfield	22c. DATE SIGNED 6/3/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/4/59	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery	23d. LOCATION (City, town, or county) Springfield, Mo.
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24. FUNERAL DIRECTOR J.W. Klingner & Co.	ADDRESS Spfld, Mo.	25. DATE RECD. BY LOCAL REG. 6-3-59	26. REGISTRAR'S SIGNATURE Effie G. Melton
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All diagnoses in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

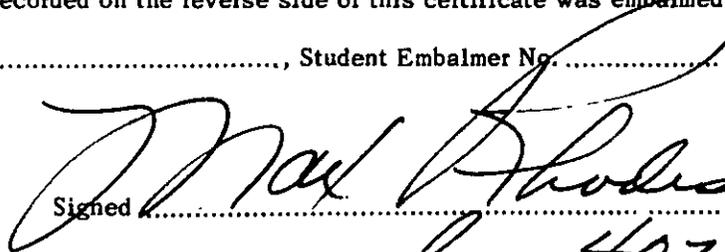
MEDICAL CERTIFICATION

300
-57

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 

Licensed Embalmer No. 407
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.