

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-030874
STATE FILE NUMBER
2 7185

FILED VS AUG 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

S. 300

v. 1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		c. CITY OR TOWN <i>St Louis</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Honolulu, Hawaii</i>		d. STREET ADDRESS (If outside, give location) <i>4457 Washington</i>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Robert Ware</i>			4. DATE OF DEATH Month Day Year <i>7-31-1959</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 13 1890</i>
9. AGE (In years, last birthday) <i>68</i>		10. USUAL OCCUPATION (Give nature of work done during most of working life. If retired) <i>Retired laborer</i>	11. BIRTHPLACE (City and state or country) <i>Ark</i>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13a. FATHER'S NAME <i>Daniel Ware</i>		13b. MOTHER'S MAIDEN NAME <i>Elzie Woods</i>	14. NAME OF HUSBAND OR WIFE <i>none</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		17. INFORMANT Address <i>Maggie Ware Manchester, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured Ribs</i> DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Acute Alcoholism</i>			19. INTERVAL BETWEEN ONSET AND DEATH <i>9:00 P.M.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <i>Suffered in fall down steps of</i>		
20c. TIME OF INJURY Hour a.m. p.m. <i>7:35 p.m.</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home on July 3 1959</i>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <i>St Louis Mo.</i>	COUNTY	STATE
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at <i>1245 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE <i>Paul Johnson</i>		22b. ADDRESS <i>300 Clark</i>	22c. DATE SIGNED <i>8/3/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8-6-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Father Dixon</i>
23d. LOCATION (City, town, or county) <i>Kirkwood Mo.</i>		23e. STATE <i>Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>A.H. Burko 3506 Franklin</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 3 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

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 *Wallace R. Williams*

Licensed Embalmer No. *4926*

P. O. Address *St. Louis*

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.