

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5867 **63-022376**
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED JUN 13 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	SHOULD READ	BY AFFIDAVIT OF
Rev. 4/59							
1							
2 10706							
3							
4 0							
5 1							
6							
7 0							
8 2							
9							
10							
11							
12 58-0							
13							
58							

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 1 day	c. CITY OR TOWN Licking
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clyde Middle Ware Last Ware			4. DATE OF DEATH Month May Day 30 Year 1963
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 3/4/1897
9. AGE (last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Licking, Missouri.
11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Ware		13b. MOTHER'S MAIDEN NAME Ira Housden	
14. NAME OF HUSBAND OR WIFE Evelyn Ware		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. N.W. 1		17. INFORMANT Address Evelyn Ware, Licking, Missouri.	
18. CAUSE OF DEATH (Enter only one cause per line) DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis with uremia			INTERVAL BETWEEN ONSET AND DEATH 2 wks.
DUE TO (b) Arteriosclerotic heart disease with hypertension and congestive failure			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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 5-29-63 to 5-30-63 and last saw her/him alive on 5-29-63 Death occurred at 4:00a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. Mueller, M.D.		22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED 5-31-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/2/63	23c. NAME OF CEMETERY OR CREMATORY Licking Cemetery	23d. LOCATION (City, town, or county) Licking, Missouri.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd		25. DATE RECD. BY LOCAL REG. JUN 3 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

OK
Keller & Taylor
Coroner 6-4-63

JUL 8 1963

JUN 13 1963

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**