EC 27 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

36503

1. PLACE OF DEATH
County Pavis
Township Jackson
City ..... (No. ....., ... St. ..... Ward)
Registration District No. 253
Primary Registration District No. 5351
File No. 13
Registered No. .....

2. FULL NAME Ben. F. Ware
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah E Ware

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18 1869

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
59	2	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jackson Twn
(STATE OR COUNTRY) Livingston Mo

PARENTS
10. NAME OF FATHER Alexander Ware
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Mildred Calahan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Camel Co Va

14. INFORMANT John T Ware
(Address) R 2 Jamesport Mo

15. FILED Dec 1, 1928 A. T. Minnick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1928, to Nov 30th, 1928, that I last saw him alive on Nov 30, 1928, and that death occurred, on the date stated above, at 3 25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congestion of Lungs
1
1111 (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Typhoid Fever
..... (duration) ..... yrs. ..... mos. 15 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no. DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) R. V. Thompson, M. D
, 19 (Address) Jamesport, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lockspring Cem
DATE OF BURIAL: Dec 2 1928

20. UNDERTAKER: F B Norman Chillicothe Mo
ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. NO. 2