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

Do not use this space.

13628

File No. 57

Registered No. 218

1. PLACE OF DEATH

27 County ~~Howard~~, Cooper, Registration District No. 218

2 Township Primary Registration District No. 3015

4 City Boonville (No. , St. Ward)

2. FULL NAME John Sam Ware,

(a) Residence, No. Fayette Mo 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 Dora Ware,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5/31/1854

7. AGE 75 YEARS MONTHS 10 DAYS 11 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri.

FATHER

13. NAME Charlie T. Ware,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri.

MOTHER

15. MAIDEN NAME Martha Robb,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri.

17. INFORMANT (ADDRESS) Mrs Reed Graves, Fayette,

18. BURIAL, CREMATION, OR REMOVAL PLACE Friend Ship. DATE 5/14 31, 19

19. UNDERTAKER (ADDRESS) Guy T. Halley. Fayette, Mo.

20. FILED 5/21, 1931 G. A. Russell, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/12/31, 19

22. I HEREBY CERTIFY, That I attended deceased from March 24, 1931, to April 12, 1931

I last saw him alive on April 12, 1931 Death is said to have occurred on the date stated above, at 6:15 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pyelonephritis	
Caused by prostatic	
hypertrophy.	1 yr

Other contributory causes of importance:

Hypostatic pneumonia

Cystostomia

Name of operation Suprapubic Date of April 2

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) [illegible], M. D.

(Address) Boonville Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 25 1931

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Cooper Registration District No. 218 File No.
Township Primary Registration District No. 3015 Registered No. 57
City Boonville (No. , St. Ward)

2. FULL NAME John Sam Ware
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5 — 31 — 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
X	76 X	10	11	

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 5/21 1931 G A Russell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 12 1931

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

DEATH OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-13626