

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.

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

Do not use this space.

DEC 14 1934

1. PLACE OF DEATH

County DeKalb
Township Washington
City Washington

Registration District No. 961
Primary Registration District No. 41601

File No. 32383
Registered No. 15
St. _____ Ward _____

2. FULL NAME

Harriett E. Ware
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>		
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Ware</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June-25-1847</u>				
7. AGE	YEARS <u>87</u>	MONTHS <u>2</u>	DAYS <u>9</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housekeeping</u>			
	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) <u>Kentucky</u>				
MOTHER FATHER	13. NAME <u>Jacob Cummings</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
	15. MAIDEN NAME <u>Harriet Groves</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
17. INFORMANT (ADDRESS) <u>Wm. Geo. Cook, Stansbelle Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Robert Gentry</u> DATE <u>Sept 6</u> 19 <u>34</u>				
19. UNDERTAKER (ADDRESS) <u>J. E. Anderson, Stansbelle Mo.</u>				
20. FILED <u>9-3</u> 19 <u>34</u> <u>J. E. Anderson</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

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21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4 1934

22. I HEREBY CERTIFY, That I attended deceased from Nov 5 1931 to Sept 4 1934
I last saw her alive on Sept 3 1934 Death is said to have occurred on the date stated above, at 5:30 p.m.
The principal cause of death and related causes of importance were as follows:
Apoplexy - 2d attack
Cerebral hemorrhage
87 y
High blood pressure
Date of onset 8-28-34

Other contributory causes of importance:
High blood pressure

Name of operation none Date of _____
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? X 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) J. E. Anderson M. D.
(Address) Stansbelle Mo

