

MAR 21 1936

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

Do not use this space.

5977

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Jean Primary Registration District No. 1002
City Kansas City (No. 12) General Hosp St. _____ Ward _____

File No. _____
Registered No. 791

2. FULL NAME

Russell Ware

(a) Residence, No. 4115 Monroe Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
46 9 11

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

13. NAME R. J. Ware

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

15. MAIDEN NAME Ida B. Brickfield

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

17. INFORMANT Peena Clark

18. BURIAL, CREMATION, OR REMOVAL PLACE General Hosp DATE 2-13-36

19. UNDERTAKER O. J. Mast

20. FILED 2/13 1936 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-12-1936

22. I HEREBY CERTIFY, That I attended deceased from 11-23, 1935, to 2-12, 1936
I last saw him alive on 2-12-1936 Death is said to have occurred on the date stated above, at 11:50 PM
The principal cause of death and related causes of importance were as follows:

Arteriosclerotic nephritis; Chronic Myocarditis; Pernicious anemia

Other contributory causes of importance: 1/31

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

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?
If so, specify _____

(Signed) [Signature] M. D.
(Address) General Hosp

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.

STATE BOARD OF HEALTH, WITH CONTINUING INTEREST THIS IS A PERMANENT RECORD

