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.

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DEC 1 AUG 4 1939

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

26420
Do not use this space.

1. PLACE OF DEATH
(a) County Osage
(b) Township Washington
(c) or City Westphalia
Registration District No. 642
Primary Registration District No. 4386
Registered No.
(d) Street No. Harwood Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

600

2. PRINT FULL NAME Clement Acton Ware
(a) Residence, No. Rehagen Hotel St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Mrs. Lettia Ware

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 7, 1852

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
87	6	5	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stock Dealer.
9. Industry or business in which work was done, as 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) Salem, New Jersey

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. Lavinia Sutton Westphalia, Mo.

18. BURIAL, ~~CREMATION OR REMOVAL~~ Riverview Cem.
PLACE Jeff City, Mo. DATE July 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John F. Heinrichs Jefferson City, Missouri

20. FILED July 12, 1939 Mary L. Player
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sebt. 23rd., 1938, to July 12th., 1939
I last saw him alive on July 12th., 1939. Death is said to have occurred on the date stated above, at 3:a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bulbar Paralysis & Diabetes.	Sebt. 24 1938.

59

Other contributory causes of importance:
Diabetic Coma.

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

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) Samuel R. Harwood, M. D.
573 (Address) Westphalia, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

John F. Heinrichs, Registered Apprentice No.....

working under my personal supervision.

Signed. John F. Heinrichs

Licensed Embalmer No. 3655

P. O. Address Jefferson City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.