

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

REGISTERED 15 1940/61

Primary Registration District No. 3024

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.

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether years, months or days)

In this community None

8. (a) PRINT FULL NAME Frederick Leon Ware

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex male 5. Color Col. race _____

6. (a) Single, widowed, married, divorced Baby

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 27 1939
(Month) (Day) (Year)

| | | | |
|---------------|--------|------|----------------------|
| 8. AGE: Years | Months | Days | If less than one day |
| 0 | 5 | 0 | br. _____ min. |

9. Birthplace Lexington Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

12. Name Gable Ware Jr.

13. Birthplace Gordon Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Norma H. Colley

15. Birthplace Lexington Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gable Ware Jr.

(b) Address 139 North-12th Street

17. (a) Burial (b) Date thereof 1-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Hill

18. (a) Signature of funeral director Raymond

(b) Address 204 S. 2nd St

19. (a) Feb. 3/1940 (b) W. Delia Davis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Lexington, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 139 North-12th Street.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Native years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 27 day _____
year 1940 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 26 1940 to Jan 26 1940
that I last saw him alive on Jan. 26 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Asstro entritis Duration 2 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. S. Cape (M. D. or other) MD
Address Lexington, Mo Date signed 1/27/40

RECEIVED
Licent Health Officer No. 8
District File Number
Date Filed 4/14/0

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.....

George Henry Green
working under my personal supervision.

Registered Apprentice No. *235*

Signed *William Hunley*

Licensed Embalmer No. *3105*

P. O. Address *204 So 34th Lexington Mo*

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

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