

No. 2
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7164**

FILED MAR 11 1943
Registration District No. **5880**

Primary Registration District No. **5880**

Registrar's No. _____

76
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Osage

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Osage (b) County Co

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Robert Henry Ware

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 1
year 1943 hour 2:00 minute _____ a.m.

4. Sex M 5. Color or Race W

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

6. (b) Name of husband or wife Lucy Bronson 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dec - 6 - 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-3-41
_____ 19____ to Feb 28 1943
that I last saw him alive on Feb 28 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 7 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Norfolk Va
(City, town, or county) (State or foreign country)

Immediate cause of death: Bilateral pneumonia
Chronic myocarditis Duration _____

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Unknown?

13. Birthplace Unknown?
(City, town, or county) (State or foreign country)

14. Maiden name Sally Davis

15. Birthplace Unknown?
(City, town, county) (State or foreign country)

Due to _____

Due to _____

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

16. (a) Informant Mrs. R. H. Ware

(b) Address _____

17. (a) Burial (b) Date thereof 3-5-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Aerial

18. (a) Signature of funeral director Clyde Martin

(b) Address _____

19. (a) 3/2/43 (b) W. A. Duroullier
(Date received local registrar) (Registrar's signature)

Major findings: Of operations 93d

Of autopsy _____

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 W. A. Duroullier (M. D. or other) _____
Address _____ Date signed _____

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Levin

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, fact should be so stated above.