V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33481

FILED NOV 13 1944

Registration District No. 1449

Primary Registration District No. 1002

Registrar's No. 4281

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: K. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1511 Tracy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 (Specify whether
In this community: 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: Jackson
(c) City or town: K.C. (If outside city or town limits, write "RURAL")
(d) Street No. 1511 Tracy (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: no

3. (a) PRINT FULL NAME: Lewis MELVIN WARE
3. (b) If veteran, name war: No
3. (c) Social Security No. none
4. Sex: MALE
5. Color or race: NEGRO
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: 3 (Month) 15 (Day) 1910 (Year)

8. AGE: Years 34 Months 7 Days 6 If less than one day hr. min.
9. Birthplace: K.C. (City, town, or county) KANSAS (State or foreign country)
10. Usual occupation: Labor
11. Industry or business:
MOTHER FATHER
12. Name: Dan. Ware
13. Birthplace: K.C. (City, town, or county) KANSAS (State or foreign country)
14. Maiden name: IONA DOONEY
15. Birthplace: Tulsa (City, town, or county) O.K. (State or foreign country)
16. (a) Informant: Dan. Ware
(b) Address: 1003 E. 14th St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-25-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Lincoln Cem.
18. (a) Signature of funeral director: Brady-Brown.
(b) Address: 1708 Tracy
19. (a) Oct 25, 1944 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21 year 1944 hour 4:15 minute a. M.
21. I hereby certify that I attended the deceased from Deputy Coroner, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Homicide	
Due to: Gun shot wound of	
Due to: Chest.	
Other conditions: Hemothorax (Include pregnancy within 3 months of death)	

Major findings:
Of operations: No
Of autopsy: yes

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): Homicide
(b) Date of occurrence: 10-21-44
(c) Where did injury occur? K.C. (City or town) Jackson (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (e) Means of injury: fire arms
23. Signature: F. Richardson (M. D. or other)
Address: 1832 Vine Date signed 10-23-44

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.