

S. No. 2
OM-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19955

Registration District No. 372

Primary Registration District No. 4543

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Seymour
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112
(c) City or town: Seymour mo.
(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 _____

3. (a) PRINT FULL NAME William Nelson Ware

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Nannie Ware 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased June 29 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Independence Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name John Ware

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

14. Maiden name Bell Ware

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

16. (a) Informant Nannie Ware (wife)

(b) Address Seymour Mo.

17. (a) Burial (b) Date thereof May 2 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seymour Cemetery

18. (a) Signature of funeral director Kelly, Ferrell, Bergin

(b) Address Seymour Mo.

19. (a) May 16 (b) Willet Jones
(Date received by local registrar) (Registrar's signature) 2110

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1947 hour 7 AM minute _____ M. _____

21. I hereby certify that I attended the deceased from 4-22 1947 to 4-25 1947
that I last saw him live on 4-25 and that death occurred on the date and hour stated above. 1947

Immediate cause of death: Pulmonary edema
weak heart.
Due to Pneumonia
Influenza

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

Major findings: _____
Of operations: _____
Of autopsy: _____

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. J. Beers (M. D. or other) _____
Address Seymour Mo. Date signed 5-7-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

12
6
0

RECEIVED

District Health Officer No. 6;

District File Number 547-572

Date Filed MAY 22 1947

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 H. H. Kelley
Licensed Embalmer No. 3334
P. O. Address Fordland 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, fact should be so stated above.