

FILED MAY 5 1949

## STANDARD CERTIFICATE OF DEATH

14258  
State File No. 3628

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY 923 N. 19 St				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURY b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St LOUIS		c. LENGTH OF STAY (in this place) 1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St LOUIS		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION 923 N 19 St				d. STREET ADDRESS (If rural, give location) 923 N. 19 St			
3. NAME OF DECEASED (Type or Print) William		a. (First)		b. (Middle) TOM		c. (Last) WARE	
4. DATE OF DEATH		4		Month		21 1949 Day Year	
5. SEX Male		6. COLOR OR RACE Colord		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 4-10-1898	
9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Abbelean Miss		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Frank Ware		13b. MOTHER'S MAIDEN NAME Callie McKinly		14. NAME OF HUSBAND OR WIFE Lucielle Ware			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499-018984		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Callie Jackson 1904 Division St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. H201					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) State		21d. (STATE) Mo	
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-5-1949, to 4-20-1949, that I last saw the deceased alive on 4-20-1949, and that death occurred at 8:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE J. F. Winston (Degree or title)				23b. ADDRESS 27437 rouplin		23c. DATE SIGNED 4-22-49	
24a. BURIAL/CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-25-1949		24c. NAME OF CEMETERY OR CREMATORY Green Wood		24d. LOCATION (City, town, or county) (State) St Louis Co, MO	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 22 1949 J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE 1405 ADDRESS Davis & Broom Biddle St					

(Licensed Embalmer's Statement on Reverse Side)

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

APR  
7 1953

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Leroy H. Pannister

Licensed Embalmer No. 46-2,3

P. O. Address 3880 Easton A

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

If this body is not embalmed, fact should be so stated above.