

FILED JUN 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16770

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BIRTH NO. _____ REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 4380 Registrar's No. 140

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, write RURAL and give town) Arkoe	c. LENGTH OF STAY (in this place) 45 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Arkoe	
d. FULL NAME OF HOSPITAL OR INSTITUTION Family Home		d. STREET ADDRESS (If rural, give location) none	
3. NAME OF DECEASED (Type or Print) a. (First) FRANKLIN	b. (Middle) CLUTCH	c. (Last) WARE	4. DATE OF DEATH (Month) (Day) (Year) 6 1 49
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/27/78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY blacksmith	11. BIRTHPLACE (State or foreign country) Barnard, Missouri	
13a. FATHER'S NAME Joseph Ware		13b. MOTHER'S MAIDEN NAME Elizabeth Maffett	14. NAME OF HUSBAND OR WIFE Ola Clawson Ware
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ola Ware, Arkoe, Missouri	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis		8 yrs
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		422
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION no operations		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. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 not attended to June 1 , 19 49 , that I last saw the deceased alive on not seen , and that death occurred at 11 A. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) L.D. Dean Coroner		23b. ADDRESS Maryville Mo	23c. DATE SIGNED 6-1-49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 6/4/49	24c. NAME OF CEMETERY OR CREMATORY Masonic	24d. LOCATION (City, town, or county) (State) Barnard, Missouri
DATE REC'D BY LOCAL REG. 6-4-49	REGISTRAR'S SIGNATURE Bess Holt	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clara M. Price Maryville, Mo.	

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 Clayton M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville 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.