

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28349

State File No.

FILED SEP 13 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3808

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> <u>0</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>3327</u>	
b. CITY OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>Unknown</u>		d. STREET ADDRESS (If rural, give location) <u>2215 Flora</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #2</u>			

3. NAME OF DECEASED (Type or Print) <u>Bennie</u>			a. (First) <u>Bennie</u>			b. (Middle) <u>Ware</u>			c. (Last) <u>Ware</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>24</u> <u>52</u>						
5. SEX <u>Male</u> <u>2</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>? -</u>			9. AGE (in years last birthday) <u>61</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours		IF UNDER 1 YEAR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Darnell, Ark.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>						

13a. FATHER'S NAME <u>? -</u>			13b. MOTHER'S MAIDEN NAME <u>? -</u>			14. NAME OF HUSBAND OR WIFE <u>Nellie Ware</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Nellie Ware, 2215 Flora</u>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardio vascular Disease</u>						<u>443x</u>	
		ANTECEDENT CAUSES							
		MORIBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) _____							
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) (Min)		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 8-22-52, 1952, to 8-24-52, 1952, that I last saw the deceased alive on 8-24-52, 1952, and that death occurred at 11:55 am., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank Ell</u> MD (Degree or title)		23b. ADDRESS <u>600 East 22nd Street</u>		23c. DATE SIGNED <u>8-25-52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>		24b. DATE <u>9-3-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>K. C. College of Osteopathy</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>8-27-52</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>2307 1/2 Lincoln</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Paul B. Graham

Licensed Embalmer No. *2540*

P. O. Address *2304 West*

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.