

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40841

State File No. _____
 Registrar's No. **10751**

FILED DEC 12 1952

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN East St. Louis	
c. LENGTH OF STAY (In this place) 5 weeks		8129	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If rural, give location) 1126 North 2nd Street	
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) _____ c. (Last) Ware			4. DATE OF DEATH (Month) (Day) (Year) 11-20-52
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 19, 1900
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) Jackson, Mississippi
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Ware		13b. MOTHER'S MAIDEN NAME Matilda Odell	14. NAME OF HUSBAND OR WIFE Emma Ware
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 352-05-9454	17. INFORMANT'S SIGNATURE OR NAME Emma Ware ADDRESS 1126 R. N. 3rd
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach with metastasis ANTECEDENT CAUSES Morbid 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"/>
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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X
22. I hereby certify that I attended the deceased from Oct. 15, 1952 , to Nov. 20, 1952 , that I last saw the deceased alive on Nov. 20, 1952 , and that death occurred at 9:30A m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Walter A. Young M.D.		23b. ADDRESS 5337 Market	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-22-52	24c. NAME OF CEMETERY OR CREMATORY Douglas	24d. LOCATION (City, town, or county) (State) East St. Louis, Illinois
DATE REC'D BY LOCAL REG. NOV 22 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE P. J. Nash	ADDRESS 111 N. 13th St

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

W. A. Young

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 M. James Nash

Licensed Embalmer No. 4734

P. O. Address 3847 Page

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.