

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012316  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 182

FILED APR 27 1959

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FAYETTE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis F. School Hospital</u>		Length of stay in lb <u>48 days</u>	d. STREET ADDRESS (If outside, give location) <u>104 N. Linn</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>WALTER</u> Last <u>WARE</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1881</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Howard county Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>William Ware</u>		13b. MOTHER'S MAIDEN NAME <u>Adeline Ware</u>		14. NAME OF HUSBAND OR WIFE <u>Annie Belle 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>unknown</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Hospital Record</u> Address <u>Columbia, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, generalized</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Perforation, stomach</u> DUE TO (c) <u>Carcinoma, stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>151X</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>151X</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20e. CITY, TOWN, OR LOCATION <u>Fayette Mo</u>	COUNTY <u>Howard</u>	STATE <u>Mo</u>
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21. I attended the deceased from 3-2-59 to 4-19-59 and last saw her alive on 4-19-59  
Death occurred at 2:30 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. J. Scheue M.D.</u> (Degree or title)	22b. ADDRESS <u>State Cancer Hospital</u>	22c. DATE SIGNED <u>4-19-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/19/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Howard County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Ralph A. Carl</u> ADDRESS <u>Fayette Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 19 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

8551 MAY 1 1977

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, ~~only~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Ralph A. Carr* .....

Licensed Embalmer No. *3340* .....

P. O. Address *Jayetta* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.