

Dec 18 1940 127

Primary Registration District No. 5276

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Clay
(b) City or town rural Gallatin
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 2

3. (a) PRINT FULL NAME Vara Waters
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased June 16, 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months 4 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

12. Name William W. Waters

13. Birthplace New Jersey
(City, town, or county) (State or foreign country)

14. Maiden name Fessie House

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer R. Waters

(b) Address Liberty, Mo. Route #2

17. (a) Burial (b) Date thereof 11-12-40
(Burial, cremation, or removal) (City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Morton Funeral Home

18. (a) Signature of funeral director _____

(b) Address North Kansas City, Mo.

19. (a) 11-14-40 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay
(c) City or town rural Gallatin
(If outside city or town limits, write "RURAL")
(d) Street No. Liberty Mo. Route #2
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV day 11
year 1940 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Nov 10, 1940, to only once, 1940;
that I last saw her alive on Nov 10, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to chronic myocarditis
Due to _____

Other conditions
(Include pregnancy within 3 months of death) ASC

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address North Kansas City Mo Date signed 11/14/40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-18-40

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.....

Harold L. Posson

Registered Apprentice No.....

working under my personal supervision.

Signed *Harold L. Posson*

Licensed Embalmer No. 3605

P. O. Address North K. C. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38485-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 197

Primary Registration District No. 5276

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Clay
(b) City or town Ballastine T. P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days) VIARA WATERS

3. (a) PRINT FULL NAME Viara Waters

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced X
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 4 25 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-14-40 (b) John Driscoll
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) Means of injury _____

23. Signature H. F. Fowler (M. D. or other)

Address H. K. C. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

62

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