

S. No. 2
OM-2-43
5-17-39
I X3565

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31021

State File No. _____
Registrar's No. 3857

FILED SEP 21 1943

149

Registration District No. _____ Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-8-43-9-2-43
(Specify whether years, months or days)

In this community 9 yrs.

3. (a) PRINTED FULL NAME: WALTER WATTS

3. (b) If veteran, name war: no

3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced, Child

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 2 1932
(Month) (Day) (Year)

8. AGE: Years 10 Months 10 Days 0

If less than one day _____ hr. _____ min.

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

10. Usual occupation School pupil

11. Industry or business _____

12. Name Columbus Watts

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

14. Maiden name Minerva Circle

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

16. (a) Informant Record Clerk

(b) Address General Hospital # 2

17. (a) Burial (b) Date thereof 9-5-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Brdy Funeral Home

(b) Address 1708 Tracy

19. (a) 9-2-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1726 Harrison
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2nd
year 1943 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from 7-8-43 to 9-2-43

that I last saw him alive on 9/2/43 and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia and Secondary Marked Anemia

Due to Chronic Lymphatic Leukemia

Due to _____

Other conditions 74a
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy As above.

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)

23. Signature P. E. Brown (M. D. or other)

Address Gen. Hosp. #2-60022 Date signed 9-2-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
[Handwritten Signature]

Licensed Embalmer No..... *1271*

P. O. Address..... *K. 6. mis*

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.