

FILED MAR 20 1948

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **982**

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:  
**5717 Garfield**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **NO.**  
 In this community **Life**  
 years, months or days (Specify whether)

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. **5717 Garfield**  
 (If rural, give location)  
 (e) Citizen of foreign country? **NO.** (Yes or No)  
 If yes, name country **X**

3. (a) PRINT FULL NAME **Oran Watts**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **486-01-1818**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mrs. Marian E. Watts** 6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **Februa ry 3 1907**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**41 0 26** hr. min.

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

10. Usual occupation **Sheet Metal Worker**

11. Industry or business **X**

12. Name **Joe Watts**

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

14. Maiden name **Agnes Ryan**

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

16. (a) Informant **Mrs. Marian E. Watts**  
 (b) Address **5717 Garfield, Kansas City, Mo.**

17. (a) **burial** (b) Date thereof **3-3-48**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C. Mo.**

19. (a) **3-2-48** (b) **Heraldine Holme**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **29**  
 year **1948** hour **12:05** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 23**, 19**46**, to **2-29**, 19**48**  
 that I last saw h. **alive** on **2-26**, 19**48**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**  
**arteriosclerosis**

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? \_\_\_\_\_

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

While at work? \_\_\_\_\_ (Specify name of place)  
 Means of injury \_\_\_\_\_  
 23. Signature **Chas. Kewens** (M. D. or other) **Chas. Kewens**  
 Address **303 Altman Bldg.** Date signed \_\_\_\_\_

Duration

**2-29-48**

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Althman*  
*Bein*  
*P.M.*

Dr. E. A. Devins

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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 *Robt H. Reed*.....

Licensed Embalmer No *3245*.....

P. O. Address *15 C ave*.....

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.