

No. 300  
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-17-39  
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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
**FILED JUL 14 1948**

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

**20393**

State File No. ....

Registration District No. 280

Primary Registration District No. 6-964

Registrar's No. 11

**1. PLACE OF DEATH:**

(a) County PLATT

(b) City or town PARKVILLE  
*Pethin*

(c) Name of hospital or institution:  
PLATT HILLS  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NO  
(Specify whether)

In this community in 1916  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO. (b) County PLATT *83*

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

(d) Street No. PLATT HILLS  
(If rural, give location)

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

If yes, name country NO

**3: (a) PRINT FULL NAME** MR. LOUIS H. WAACK

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month JUNE day 27  
year 1948 hour 6 minute 30 A M.

**21. I hereby certify that I attended the deceased from** Nov 1945  
2, 1945, to June 1948, 1948;  
that I last saw h. alive on 6-2-48, 1948;  
and that death occurred on the date and hour stated above.

4. Sex M. 0 5. Color or race W

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

6. (b) Name of husband or wife MARY JANE WAACK

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

7. Birth date of deceased OCT. 27 1875  
(Month) (Day) (Year)

Immediate cause of death Uremia *Duration*

Due to Carcinoma, Bladder

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 52 B

Of autopsy .....

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

**8. AGE:** Years 74 Months 8 Days 0  
If less than one day hr. ... min. ...

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

10. Usual occupation RETIRED

11. Industry or business .....

**MOTHER FATHER**

12. Name JOACHIM WAACK *4*

13. Birthplace GERMANY

14. Maiden name WILHELMINA REICHOFF *4*  
(City, town, or county) (State or foreign country)

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

16. (a) Informant JOHN C. MURPHREE

(b) Address PARKVILLE, MO.

17. (a) BURIAL \* (b) Date thereof 6-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director STINE & MCCLURE

(b) Address KANSAS CITY, MO.

19. (a) June 29-48 (b) Aphie Ballin  
(Date received local registrar) (Registrar's signature)

**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?

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

23. Signature T. E. ... (M. D. or other) ...

Address 1019 Craig - Platt Date signed 6-28-48

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 7-9-48

AUG 25 1948  
JUL 1 1948

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 Robert N Reed

Licensed Embalmer No. 3745

P. O. Address NC 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.**