

FILED MAR 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5203

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 715

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 5501 E. 10 St.	
3. NAME OF DECEASED (Type or Print) a. (First) Walter		c. (Last) Winters	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) 2 12 1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 10-9-1891
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Winters		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mary Winters	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriolar nephrosclerosis	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 14 days	
DUE TO (c) Uremia		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 442x	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Jan. 29, 1949, to Feb. 12, 1949, that I last saw the deceased alive on Feb. 12, 1949, and that death occurred at 7:13 P.M., from the causes and on the date stated above.	
23a. SIGNATURE Wm. W. Hart (Degree or title)		23b. ADDRESS Med. Dir. Gen'l Hosp.	
23c. DATE SIGNED 2-14-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-15-49		24c. NAME OF CEMETERY OR CREMATORY Mt Washington	
24d. LOCATION (City, town, or county) (State) R.C. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John P. Smith	
DATE REC'D BY LOCAL REG 2-15-49		REGISTRAR'S SIGNATURE Geraldine Holmes	
25. FUNERAL DIRECTOR'S ADDRESS R.C. Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

*An American*

---

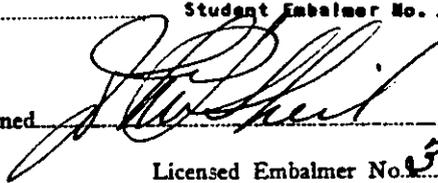
---

**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 \_\_\_\_\_

.....  
Student Embalmer No. ....  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed .....  
Licensed Embalmer No. 3625

P. O. Address R. C. W.

**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.