

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42479

State File No. 5575

FILED JAN 5 1953

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri		b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 2 Wks.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Liberty	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research		d. STREET ADDRESS (If rural, give location) 20 Terrace			

3. NAME OF DECEASED (Type or Print) Baxter			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Dec. 17-52		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 31-1873	9. AGE (In years last birthday) 79		10 UNDER 1 YEAR 8 Months	10 UNDER 1 YEAR 16 Days	10 UNDER 24 HRS. Hours	10 UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (City and State or Foreign Country) Rolls Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME Geo. W. Waters	13b. MOTHER'S MAIDEN NAME Lavenia Smith	14. NAME OF HUSBAND OR WIFE Ruth Myers Waters
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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. No	17. INFORMANT'S SIGNATURE OR NAME William Waters		ADDRESS Liberty, Mo.	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH 11 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			33 1/2

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 12-8, 1952, to 12-17, 1952, that I last saw the deceased alive on 12-16, 1952, and that death occurred at 12:40 Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>James H. Skelton</u> MD	(Degree or title)	23b. ADDRESS Liberty, Mo.	23c. DATE SIGNED 12-18-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec. 17-52	24c. NAME OF CEMETERY OR CREMATORY Fairview	24d. LOCATION (City, town, or county) (State) Liberty, Mo.
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DATE REC'D BY LOCAL REG. 12-19-52	REGISTRAR'S SIGNATURE <u>Theraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Church - Owen Co. Liberty, Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300
EV. 10.48

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JAN 27 1953

JAN 9 1953

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.

Student
Student Embalmer

Signed Harold G. Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, 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.