

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43236**
5750

FILED DEC 23 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 Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 18 Months		e. STREET ADDRESS (If rural, give location) 4620 Charlotte Street 36680	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) RUTH		b. (Middle) _____	c. (Last) WATSON	4. DATE OF DEATH (Month) (Day) (Year) Dec. 4, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH July 31, 1890	9. AGE (In years last birthday) 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Cherokee, Kansas /	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Robert Poage Strain		13b. MOTHER'S MAIDEN NAME Mary R. Fletcher		14. NAME OF HUSBAND OR WIFE R. C. S. Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY (If yes, give war or dates of service) 459-22-6004		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. N. S. Shannon Kansas City, Mo.	

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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver.		INTERVAL BETWEEN ONSET AND DEATH about 2 years.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nutritional Deficiency		
	DUE TO (c) Unknown.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5810			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION none.	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	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) no	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from **9-9**, 19**53**, to **92-14**, 19**53**, that I last saw the deceased alive on **12-3**, 19**53** and that death occurred at **5:20 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE W. A. Myers, M.D.	(Degree or title) D	23b. ADDRESS 1115 Grand Ave. Kansas City	23c. DATE SIGNED 12-4-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-7-53	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, township) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 12-7-53	REGISTRAR'S SIGNATURE Sheldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Fr. St. A. Stephens

St. Louis 13669.

No. 3925.

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.....
Signature of Student Embalmer

Signed.....
J. S. Freeman

Licensed Embalmer No. *2939*

P. O. Address *F. O. St.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.