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FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005935
STATE FILE NUMBER 594

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) KANSAS CITY — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LUKES HOSP. — Length of stay in 1b 50 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2116-E-74TH ST. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ELLA Middle G. Last WATSON
4. DATE OF DEATH Month FEB Day 1 Year 1958

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH JAN-24-1869
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

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 country) GRAY SUMMIT, MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM TRIPLETT
13b. MOTHER'S MAIDEN NAME SUSAN A STANLEY
14. NAME OF HUSBAND OR WIFE CHARLES C. WATSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT MISS NELLE WATSON Address 2116-E-74 KC MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH 3 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Auricular fibrillation — 2 weeks
DUE TO (c) Arteriosclerosis — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4331

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-10-58, to 2-1-58 and last saw her alive on 2-1-58
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. L. Spafford M.D.
22b. ADDRESS 1414 Prof. Bldg. Kansas City Mo
22c. DATE SIGNED 2-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE FEB-4-1958
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.
23d. LOCATION (City, town, or county) KANSAS CITY (State) MO

24. FUNERAL DIRECTOR D.W. NewComers Sons ADDRESS 1230 BRUSH CREEK Kan. City, Mo.
25. DATE RECD. BY LOCAL REG. 2-4-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

A. L. Spafford

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 Robert Ray

Licensed Embalmer No. 4 15

P. O. Address K. C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.