

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010254
STATE FILE NUMBER 1509

FILED APR 9 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

Health, Welfare, Public Service

300
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
James W. Fowler

Doctor, coroner, etc.: most use only standard nomenclature. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5430 Holmes		Length of stay in lb 58 yrs	d. STREET ADDRESS 5430 Holmes		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ISABELLE Middle C. Last WATERS			4. DATE OF DEATH Month 3 Day 22 Year 58		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1874		9. AGE (In years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Cleveland, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hobart R. Searle		13b. MOTHER'S MAIDEN NAME Isabelle Boxall	
14. NAME OF HUSBAND OR WIFE Fred R. Waters		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 Juanita Forgey		Address 4036 Locust, K.C. Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE					INTERVAL BETWEEN ONSET AND DEATH 1 HR.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE					5 YRS.
DUE TO (c) OSTEITIS DEFORMANS					4221
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 DEC 1955 to MAR 22 1958 and last saw her alive on FEB 12 1958 Death occurred at 8:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James W. Fowler, M.D.			22b. ADDRESS 1103 GRAND AVE. KANSAS CITY, MO.		22c. DATE SIGNED MAR 22, '58
23a. BURIAL, CREMATION, REBURY (Specify) Burial		23b. DATE 3-26-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington		23d. LOCATION (City, town, or county) (State) Kansas City, Mo
24. FUNERAL DIRECTOR Wagner Funeral Home, N. G. Mo		ADDRESS		25. DATE RECD. BY LOCAL REG. 3-22-58	26. REGISTRAR'S SIGNATURE Neve Minshall

BA 1-0630
1:00



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 *Thomas D. [Signature]*

Licensed Embalmer No. *4995*

P. O. Address *201 [Signature]*

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.