

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023620

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1810

AMENDED

FILED JUL 5 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>37 West Drake Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>37 West Drake Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH WALDO WATERMAN</u>			4. DATE OF DEATH Month Day Year <u>June 29 1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Smith & Davis Mfg</u>	11. BIRTHPLACE (City and state or country) <u>Clarinda, Iowa</u>
13a. FATHER'S NAME <u>Cassius M. Waterman</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Skinner</u>	14. NAME OF HUSBAND OR WIFE <u>Hazel C. Waterman</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>J.W. Waterman, 447 Forest Green, W.G. Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Distention for Coronary Thrombosis dependent on atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arterio-sclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 WORK <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 <u>11-25-52</u> to <u>6-29-61</u> and last saw ^{her} him alive on <u>5-11-61</u> Death occurred at <u>5:25 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Gene H. Murphy M.D.</u>		22b. ADDRESS <u>354 Central, Clayton, Mo.</u>	22c. DATE SIGNED <u>6-29-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7/1/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clarinda Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clarinda, Iowa</u>
24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-29-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Wester Gro

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.