

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027382 ✓

3753

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3753

FILED AUG 2 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>6004</u>				
3				
4 <u>0</u>				
5 <u>2</u>				
6				
7 <u>0</u>				
8 <u>2</u>				
9 <u>6000</u>				
10				
11				
12 <u>86-0</u>				
13				
	SHOULD READ			
	ITEM NO.			
	BY AFFIDAVIT OF			

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City Mo.</u>		Length of stay in 1b <u>20 years.</u>	c. CITY OR TOWN <u>North Kansas City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4001 Warwick</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2103 Gentry</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Jesse</u> Last <u>Waers</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/82</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesaler</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mosby, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Hine Webster Waers</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Susan Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Waers</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. <u>  </u>	
17. INFORMANT <u>John Nickolson, Kansas City, Mo.</u>		Address <u>4807 Malone Court.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
DUE TO (c) <u>  </u>		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	
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>	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>5-21-56</u> to <u>7-16-62</u> and last saw her/him alive on <u>7-11, 1962</u>		Death occurred at <u>8:30/A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Edward A. Fischer M.D.</u>		22b. ADDRESS <u>306 E. 21st Ave., North K.C. Mo.</u>	22c. DATE SIGNED <u>7-16-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 18, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kearney Mo.</u>
24. FUNERAL DIRECTOR <u>Melody McGilley-Eylar, Kansas City North, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-18-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth A Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Hal Bloumberg*

Licensed Embalmer No.

*3408*

P. O. Address

*Indep, 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.