

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

12935

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis, Mo. (No. Mo. Baptist Hospital)..... St. .... Ward)

File No.....  
 Registered No. 3486

**2. FULL NAME** Harry Waters

(a) Residence No. 4242 Folsom St. 18 Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to March 20, 1929, that I last saw him alive on Mar 20, 1929, and that death occurred, on the date stated above, at 8:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Multiple Abscesses of liver -  
115 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY Pneumonia Alveolaris  
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Jan 26-1929

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Lloyd L. Heid, M. D.  
 (Address) 306 Lindell Trust Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Albion, Ill. DATE OF BURIAL Mar. 22, 1929

20. UNDERTAKER E. G. Hale and Son, Albion, Ill. ADDRESS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mamie Waters

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 17, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
55 2 3

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Tobacco Worker  
 (b) General nature of industry, business, or establishment in which employed (or employer) Liggett-Myers Co.  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Albion  
 (STATE OR COUNTRY) Ill.

10. NAME OF FATHER Geo. Waters

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) England

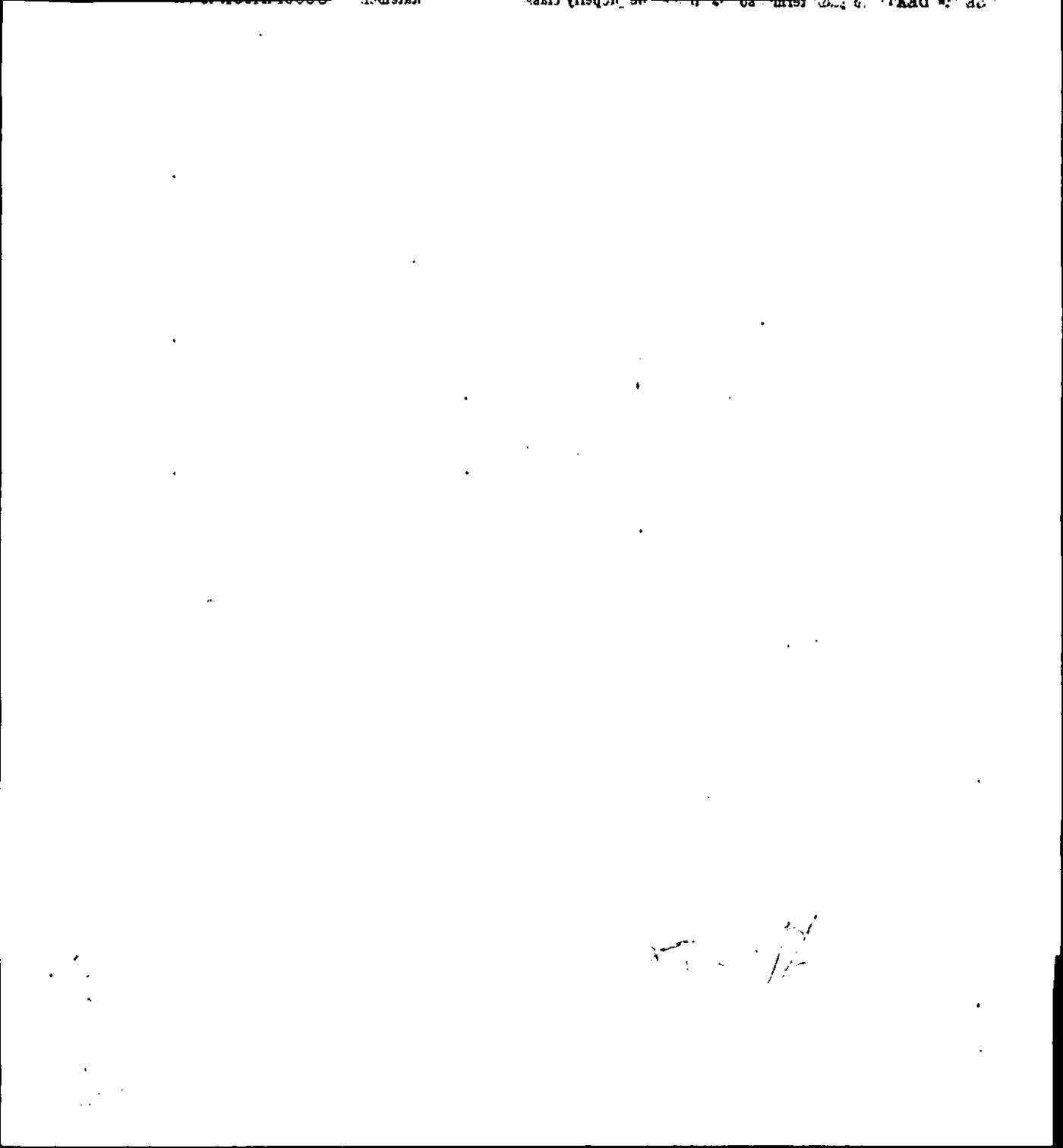
12. MAIDEN NAME OF MOTHER Mary Newport

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Geo. A. Staters  
 (Address) 58 1/2 Heidecker

15. FILED 20, 1929 Jan. C. Banker REGISTRAR

78  
2  
8  
31



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No. ....  
 Township..... Primary Registration District No. 1003 Registered No. 3486  
 City St. Louis (No. ....) St. .... Ward

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) div

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 11/11-6 1919 Maye Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/20 1929

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... that I last saw h. .... alive on 19... and that death occurred, on the date stated above, at ..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Multiple lacerations  
to head non traumatic  
cause unknown information  
from phone by Dr. R. Heide  
 CONTRIBUTORY (SECONDARY) Div. of W. D. 5-22-29 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? DATE OF...  
 WAS THERE AN AUTOPSY...  
 WHAT TEST CONFIRMED DIAGNOSIS...  
 (Signed) 124A M. D.  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 CAUSE OF DEATH in plain terms, that it may be properly stated.

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