

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

Do not use this space.

40717

1. PLACE OF DEATH

County Jackson Registration District No. apt-705 File No. 51029
 Township Law Primary Registration District No. 10 Registered No. 51029
 City K.C.Mo (No. 488) Roanoke Park Way (Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OF RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 30-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
66 8 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Photographer
 (b) General nature of industry, business, or establishment in which employed (or employer) self
 (c) Name of employer

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

10. NAME OF FATHER Samuel Watters

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

12. MAIDEN NAME OF MOTHER Mary King

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

14. INFORMANT (Address) Mrs Ella Watters
East Wood Hills

15. FILED 12/29 19 29 M. McNamee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-11 19 29

17. I HEREBY CERTIFY, That I attended deceased from 10-1 19 29, to 12-11 19 29, that I last saw him alive on 12-10 19 29, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilation of
92A Heart
95B

(duration) 1 yrs. — mos. — ds.
 CONTRIBUTORY (SECONDARY) mitral insufficiency
 (duration) 1 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED 90W

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? no DATE OF no

WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Physical signs
 (Signed) W. H. Halls M. D.

12-11 19 29 (Address) Raytown Mo

*State the DISEASE CAUSING DEATH, or if 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 Forest Hill DATE OF BURIAL 12-13 19 29

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

