

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.

REC'D JUN 8 1938

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

19847  
Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903  
(b) Township Witchell Primary Registration District No. 4545  
(c) City Grant City (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred 18 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 18 yrs. mos. ds.

2. PRINT FULL NAME

Charles Rosyth Water 260  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Annie C. Water</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 26, 1857</u>		
7. AGE YEARS <u>80</u>	MONTHS <u>5</u>	DAYS <u>8</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>		11. Total time (years) spent in this occupation <u>life</u>
9. Industry or business in which work was done, as saw mill, bank, etc.		10. Date deceased last worked at this occupation (month and year) <u>14-25</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Philadelphia Penn.</u>		
13. NAME <u>John Water</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>		
15. MAIDEN NAME <u>Jeanne Palmer</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>		
17. INFORMANT (ADDRESS) <u>Annie C. Water Grant City Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Wingold Cem.</u> DATE <u>5/6/38</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Arch C. Duffee Grant City, Mo.</u>		
20. FILED <u>6-7</u> 19 <u>38</u> <u>Fred Mull, M.D.</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-4 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h..... alive on..... 19\_\_\_\_. Death is said to have occurred on the date stated above, at 7:30 P.M.

The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis Date of onset 12/1

Other contributory causes of importance:  
Chrom. Nephrit.

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19\_\_\_\_  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....  
(Signed) Hentley Neal, D.D. (Address) Grant City, Mo.

**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, .....

*myself*

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*Arch C. Dunfee*

Licensed Embalmer No.....

*3252*

P. O. Address.....

*Grant City, 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 this body is not embalmed, above space should be left blank.**