

Registration District No. **723**

Primary Registration District No. **5578**

Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **JEFFERSON**  
 (b) City or town **near Kimmswick, Rock**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location) **2**  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days **2 1/2**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **JEFFERSON**  
 (c) City or town **near Kimmswick Mo**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **Rural**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME **GEORGE D. WATERHALL**

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lephe** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **March 16th 1850**  
 (Month) (Day) (Year)

8. AGE: Years **90** Months **4** Days **15** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis Mo.**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business  
 MOTHER FATHER { 12. Name **William Waterhall**  
 13. Birthplace **England** 4  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Mrs. Emma**  
 15. Birthplace **New York** 1  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Hoag**  
 (b) Address **St. Louis Mo.**

17. (a) **BURIAL** (b) Date thereof **AUG 4 1940**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Federical town Cemetery**

18. (e) Signature of funeral director **HEINIGTAG FUNERAL HOME**

(b) Address **KIMMSWICK MO.**

19. (a) **8-3-1940** (b) **Phil G. Link**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1**  
 year **1940** hour **4** minute **5 4 M.**

21. I hereby certify that I attended the deceased from **Nov. 20, 1937** to **July 31, 1940**  
 that I last saw him alive on **July 31, 1940**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** **1 wk.**

Due to **acute nephritis** **2 mo.**

Due to \_\_\_\_\_

Other conditions **pt. hemiplegia** **11 yrs.**  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: **no operation**  
 Of operations \_\_\_\_\_  
 Of autopsy **none**  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **3/11**

(Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **M. T. Morrison M.D.** (M. D. or other) \_\_\_\_\_

Address **Kimmswick, Mo** Date signed **8-3-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X21492

SEP 23 1940

120

**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Elmer Heiligtag

Licensed Embalmer No. 3571

P. O. Address Kimberwick MA

**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.

Registration District No. **421**

Primary Registration District No. **2576**

Registrar's No. **82**

**1. PLACE OF DEATH:**  
 (a) County **Jefferson**  
 (b) City or town **Rock T.P.**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay! In hospital or institution:  
 In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Geo. D. Waterall**  
 3. (b) If veteran, name war  
 3. (c) Social Security No.

4. Sex **m**  
 5. Color or race **w**  
 6. (a) Single, widowed, married, divorced **m**  
 6. (b) Name of husband or wife  
 6. (c) Age of husband, or wife, if alive

7. Birth date of deceased.  
 (Month) (Day) (Year)

8. AGE:  
 Years **90** Months **4** Days **15**  
 If less than one day, hr. min.

9. Birthplace  
 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER  
 { 12. Name  
 { 13. Birthplace (City, town, or county) (State or foreign country)  
 { 14. Maiden name (City, town, or county) (State or foreign country)  
 { 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant  
 (b) Address

17. (a) (b) Date thereof.  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation

18. (a) Signature of funeral director  
 (b) Address

19. (a) (b)  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State (b) County  
 (c) City or town  
(If outside city or town limits write "RURAL")  
 (d) Street No.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? years.

**20. DATE OF DEATH:** Month **Aug** day **1**  
 year **1940** hour minute M.  
**21. I hereby certify that I attended the deceased from**  
 19 to 19  
 that I last saw him alive on 19  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death **uremia**

**Due to** **acute nephritis**  
**unknown cause**  
**Due to**  
 Other conditions **Rt. Hemiplegia** 10 yrs.  
(Include pregnancy within months of death)  
**probably cerebral embolage**  
 Major findings: **no operation**  
 Of operations  
 Of autopsy **none 82k**

**22. If death was due to external causes, fill in the following:**  
 (a) Accident, suicide, or homicide (specify)  
 (b) Date of occurrence  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)  
 While at work? (e) Means of injury  
**23. Signature** **W. T. Morrison, M.D.** (M. D. or other)  
**Kimberwick, Mo** Date signed **10-12-40**

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

