FILED JUL 17 1942

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

22538

Do not use this space.

1. PLACE OF DEATH

(a) County Wayne — Registration District No. 890

(b) Township [illegible] — Primary Registration District No. 6195 — Registered No.

(c) or City Coldwater, Missouri — Street No. 1 — St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME Joseph Waters

(a) Residence, No. 412 Garden Street, Hot Springs, Ark. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Don't know

7. AGE: Years: About four — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

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)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis, Missouri

FATHER

13. NAME: James T. Waters

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Watertown, Tenn.

MOTHER

15. MAIDEN NAME: Thelma Brown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Missouri

17. INFORMANT (ADDRESS): William Brown St. Louis

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Louis DATE June 23 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS): William Coder Piedmont, Mo

20. FILED 6-22 1942 Inez Bennett Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 21 1942

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 ....m.

The principal cause of death and related causes of importance were as follows:

Acidental death due to automobile crash

Date of onset

Other contributory causes of importance:

170 C

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? Accident Date of injury June 21

Where did injury occur? Coldwater, Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. On Highway 67

Manner of injury Concussions

Nature of injury Broken bones

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) T. C. Giles Coroner, M. D.

(Address) Piedmont, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

I X16605

RECEIVED

District Health Officer No. 4

District File Number 742-865

Date Filed 7-10-42

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 Coder Funeral Home, Registered Apprentice No. _____ working under my personal supervision.

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Piedmont, 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.

. S. No. 2B
OM—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 890 Primary Registration District No. 6195 Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Wayne

(b) City or town: Coldwater (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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Ark (b) County:

(c) City or town: Hot Springs (If outside city or town limits, write "RURAL")

(d) Street No.: 412 Garden St (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Joseph Waters

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: B

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

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

8. AGE: Years Months Days 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:

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

16. (a) Informant:

(b) Address:

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

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June Day: 2, year: 1942 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: Duration

Due to: Pleural Effusion

Due to: Congestive Cardiac Failure through

Due to: Cardiac Decompensation

Due to: Cardiac Hypertrophy

Other conditions (Include pregnancy within 3 months of death): Old Tuberculosis

Major findings of operations: Bronchial Fistula

Of autopsy: Chronic Pleural Effusion

PHYSICIAN: 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): Not Accident

(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: T. C. Giles (M. D. or other): Coroner

Address: Date signed:

SUPPLEMENTARY

Nov 21

S-22538