

FILED AUG 17 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2946

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: General Hospital No. 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7-26-42-8-1-42  
 (Specify whether years, months or days) 39 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3937 Wayne  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** WILLIAM H. WATERS  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. 709-16-2918

4. Sex Male 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Sadie Waters  
 6. (c) Age of husband or wife if alive 48 years  
 7. Birth date of deceased June 6 1873  
 (Month) (Day) (Year)

**8. AGE:**  
 Years 69 Months 1 Days 26  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unemployed

**11. Industry or business**  
 12. Name Azariah Waters  
 13. Birthplace unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Catherine Waters  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
 (b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 8-4-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Highland

18. (a) Signature of funeral director M. H. Brown  
 (b) Address 1820 E-18th St

19. (a) 8-4-42 (b) M. H. Brown  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month August day 1  
 year 1942 hour 1 minute 20 a. M.

21. I hereby certify that I attended the deceased from July 26 1942 to August 1 1942  
 that I last saw him alive on August 1 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Cerebral Arteriosclerosis

Due to Hypertensive type heart disease

Other conditions 9315  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 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) \_\_\_\_\_  
 (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? \_\_\_\_\_

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

23. Signature J. O. Drouillard (M. D. or other)  
 Address Gen. Hosp #2-605 E 22 Date signed 8-3-42

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

Mc

PAID 281941

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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 me  
AB Moore, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed AB Moore  
Licensed Embalmer No. 2410  
P. O. Address 1820 East 18th

**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, fact should be so stated above.**