

FILED AUG 9 1944

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **3053**

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 4-24-44-7-22-44
(Specify whether years, months or days)
 In this community 28 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. 2453 Tracy
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME JULIA WATROUS
 (b) If veteran, name war no
 (c) Social Security No. none

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Widow 2
 (b) Name of husband or wife Unknown
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased October 23 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	8	2029	hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER
 12. Name Don't Know
 13. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know
 15. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

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

17. (a) Cremial (b) Date thereof 7-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Blythe Ridge Cem.

18. (a) Signature of funeral director Hest. Appleton-Jones
 (b) Address City

19. (a) 7-24-44 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 22
 year 1944 hour 11:05 minute A. M.
 21. I hereby certify that I attended the deceased from April 24
 1944, to July 22, 1944
 that I last saw h. or alive on July 22, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
(Thrombo Angiitis Obliterans)
 Duration _____

Due to Gangrene of lower third of left leg

Due to Generalized Arterio Sclerosis

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

Major findings: 94.2 -
 Of operations _____
 Of autopsy _____
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) (a) Means of injury

23. Signature H. E. Brown (M. D. or other) _____
 Address Gen. Hosp. #2 605 E. 22nd Date signed 7/24/44

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

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 _____

C. J. West

Licensed Embalmer No. _____

2710

P. O. Address _____

K. C. 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, fact should be so stated above.