

Registration District No. 199

Primary Registration District No. 1002

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

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. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hrs. 45 mins.
(Specify whether years, months or days)

In this community 34 YEARS

3. (a) PRINT FULL NAME FLORENCE Edna Watt

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MR. ARCHIBALD S. WATT

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased DECEMBER 19 1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>6</u>	<u>6</u>	hr. min.

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

10. Usual occupation HOUSEWIFE

MOTHER FATHER

11. Industry or business

12. Name JOHN PARKEY

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

14. Maiden name UNKNOWN

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

16. (a) Informant ARCHIBALD S. WATT

(b) Address 2411 1/2 TROOST AVE., K.C., Mo.

17. (a) BURIAL (b) Date thereof JULY 3 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILL'S CEMETERY

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401-BRUSH GREEN BLDG.

19. (a) 7-3-47 (b) Edna Watt
(Date received local registrar) (Registrar's signature)

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. 2411 1/2 Troost
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1947 hour 1 minute 25 P.M.

21. I hereby certify that I attended the deceased from June 25, 1947 to June 25, 1947
that I last saw her alive on June 25, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 940

Major findings: Of operations _____

Of autopsy None

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? U

While at work? (Specify type of place) _____

(c) Months of injury _____

23. Signature Wm W. Ward (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 6-26-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Bernard L. Horan
Licensed Embalmer No. 4250
P. O. Address W.C. Moore

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.