

FILED AUG 13 1948

Registration District No. **23**

Primary Registration District No. **5291**

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County **Liberty**

(b) City or town **Liberty (Rural)**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **200 F. Hosp.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: **10 yrs**
(Specify whether in this community, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Clay 24**

(c) City or town **Liberty**
(If outside city or town limits, write "RURAL")

(d) Street No. **200 F. Home**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **CHARLES E. WAITERS**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

4. Sex **male** 5. Color or race **Wh**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Cora M**

6. (c) Age of husband or wife if alive **23** years

7. Birth date of deceased **May 23 - 1864**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **6**
year **1948** hour **8** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **March 17** 19**47** to **Aug. 6** 19**48**
that I last saw him alive on **Aug 5** 19**48**
and that death occurred on the date and hour stated above. Duration

Immediate cause of death: **Acute circulatory failure 36 hrs.**

8. AGE:

Years	Months	Days	If less than one day
84	2	13	hr. min.

Due to **Hypertensive cardio-vascular disease 20 yrs.**

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

10. Usual occupation **furniture worker**

Other conditions **Surgical absence, both legs. 15 yrs.**
(include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business **✓**

12. Name **Charles Walters**

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

14. Maiden name **Ann Ann Beck**

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

Major findings: **MI**

Of operations **MI**

Of autopsy **MI**

16. (a) Informant **200 F. Home Records**

(b) Address **Liberty Mo**

17. (a) **Removal** (b) Date thereof **8/7/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Louis Mo.**

18. (a) Signature of funeral director **Punch-Graves Co.**

(b) Address **Liberty Mo.**

19. (a) **8.6.1948** (b) **Marion Haynes**
(Date received local registrar) (Registrar's signature)

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 **D**

23. Signature **S. O. Schroeder** (M. D. or other) **M. D.**

Address **Liberty, Mo.** Date signed **8/6/48**

PHYSICIAN

Underline the cause of which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-12-78

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 John Lombard

Licensed Embalmer No. 4448

P. O. Address Liberty 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.