

UNIVERSAL DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26661**
3134
Registrar's No. _____

FILED AUG 26 1948
Registration District No. **779**

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: **Northeast Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 hrs.** (Specify whether years, months or days)
In this community **7 hrs.**

3: (a) PRINT FULL NAME **WATSON, Infant**
3. (b) If veteran, **no** name war
3. (c) Social Security No. **no**

4. Sex **Male** 0
5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **S** 0
6. (b) Name of husband or wife **--**
6. (c) Age of husband or wife if alive **--** years
7. Birth date of deceased **7/31/48**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 **0** **0** **7** hr. **0** min.

9. Birthplace **Kansas City** **Mo** 0
(City, town, or county) (State or foreign country)

10. Usual occupation **--**

11. Industry or business **--**

MOTHER FATHER {
12. Name **Charles Watson**
13. Birthplace **Kansas City** **Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Maria Gonzalez**
15. Birthplace **Mexico City, Mexico** 0
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Watson**
(b) Address **4720 E 6th St.,**

17. (a) **Burial** (b) Date thereof **7/31/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **John P. Sheil**
(b) Address **Kansas City, Mo.**

19. (a) **7-31-48** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Jackson** 48
(c) City or town **Kansas City** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **4720 E 6th St.,** 8
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **31**
year **1948** hour **1** minute **A** M.
21. I hereby certify that I attended the deceased from **7/31 1am**
1948 to **7/31 8am** 19**48**
that I last saw him **alive** on **7/31**
and that death occurred on the date and hour stated above **1948**

Immediate cause of death **acute Respiratory failure** Duration
Due to **Premature Birth**

Due to **Contusion of Brain due to Probr.**
Other conditions **160.C.**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____

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)
(e) Means of injury _____
23. Signature **[Signature]** (M. D. or other) **no**
Address **2722 Prospect** Date signed **7/31/48**

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.....

Charles E Mayfield....., Registered Apprentice No. 18
working under my personal supervision.

Signed John P Shud.....
Licensed Embalmer No. 3625
P. O. Address 6640.....

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.