

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

39425

State File No.

FILED DEC 10 1953

BIRTH NO.		REG. DIST. NO. <u>150</u>		PRIMARY REG. DIST. NO. <u>5572</u>		Registrar's No. <u>213</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON COUNTY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Prairie Township</u>		c. LENGTH OF STAY (in this place) <u>15 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>R 4 Independence, Mo</u>		7000	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jackson County Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R 4 Independence, Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Herbert</u>		b. (Middle)		c. (Last) <u>Waller</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 23 53</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>2-19-1878</u>	
9. AGE (In years last birthday) <u>75</u>		10. MONTHS <u>9</u>		11. DAYS <u>4</u>		12. IF UNDER 1 YEAR Hours <u>4</u> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jackson Cty Hosp.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARDIAC FAILURE</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>15 days.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>no</u>		4500	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>Nov 8, 1953</u> , to <u>Nov 23, 1953</u> , that I last saw the deceased alive on <u>Nov 23, 1953</u> , and that death occurred at <u>7:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Donald Watson M.D.</u>		23b. ADDRESS <u>County Hospital, Jackson</u>		23c. DATE SIGNED <u>11-24-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Nov 25, 53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kansas</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 25-53</u>		REGISTRAR'S SIGNATURE <u>N. B. Langford</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>N. B. Langford, Leek Summit Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4822

P. O. Address _____

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.