

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038603

FILED VS. OCT 27 1960

149

Primary Registration District No. 1002

Registrar's No.

5104

STATE FILE NUMBER

|  |  |   |  |  |   |  |   |       |  |
|--|--|---|--|--|---|--|---|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |   |  |   |       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Kansas City</b>  |  | Length of stay in 1b<br><b>25 Yrs</b>   |  | c. CITY OR TOWN<br><b>Kansas City</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>General Hospital</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>307 Barat</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NANCY</b> Middle <b>MAE</b> Last <b>WATERS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>9</b> Year <b>1960</b>   |   |  |   |       |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/24/79</b>  | 9. AGE (last birthday)<br><b>25 80</b>                            | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Van Buren Ark</b>                            |  | 11. BIRTHPLACE (City and state or country)<br><b>USA</b>          |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |       |  |
| 13a. FATHER'S NAME<br><b>John Watkins</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Malisica Graham</b>                                  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>John Waters (Dec)</b>  |   |       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>Address <b>Mrs Maye Jones 307 Barat K C Mo</b>   |  |   |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ovarian Carcinoma</b> |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                       |  |   |  |  |   |  |   |       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                        |  |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/>  | HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |  |   |       |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.  |  | Month, Day, Year  |  |  |   |  |   |       |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>NOT WHILE AT WORK <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION   |   | COUNTY   |   | STATE |  |
| 21. I attended the deceased from <b>9-24-60</b> to <b>10-9-60</b> and last saw her/him alive on <b>10-9-60</b>   |  |   |  | Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.                               |   |  |   |       |  |
| 22a. SIGNATURE<br><b>H L Dwyer md</b>  |  |   |  | 22b. ADDRESS<br><b>2400 Cherry</b>   |   | 22c. DATE SIGNED<br><b>10-10-60</b>  |   |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>10/10/60</b>           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Lawn Cem.</b>  |  | 23d. LOCATION (City, town, or county)<br><b>Van Buren Arkansas</b>   |   | (State)  |   |       |  |
| 24. FUNERAL DIRECTOR<br><b>Sheil Funeral Home Kansas City Mo</b>   |  |   |  | ADDRESS  |   | 25. DATE RECD. BY LOCAL REG.<br><b>10-10-60</b>  | 26. REGISTRAR'S SIGNATURE<br><b>H-L. Dwyer</b>  |       |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed *Thomas B. Smith*

Licensed Embalmer No. 4953

P. O. Address J. P. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.