

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-015530

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2203 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 7 1962

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 3668	
3	
4 0	
5 1	
6	
7 1	
8 0	
9 443X	
10	
11	
12 760	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in 1b 10 1/2 Days	c. CITY OR TOWN KANSAS CITY, MO. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 231 E 46th St., KC, Mo. Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ORVAL WATTERS			4. DATE OF DEATH Month Day Year APRIL 19, 1962
5. SEX MALE	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/30/92
9. AGE (last birthday) 70 69		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY INVESTMENTS SELLING	11. BIRTHPLACE (City and state or country) NEBRASKA CITY, NEBR. U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME CHARLES WATTERS	13b. MOTHER'S MAIDEN NAME ADA TROUP
14. NAME OF HUSBAND OR WIFE NELL Q. WATTERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 12/21/18 to 3/26/19	
16. SOCIAL SECURITY NO.		17. INFORMANT Address VA HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontile hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 17 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive and arteriosclerotic cardiovascular disease			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> 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. Attended the deceased from 4/2/62 to 4/19/62 and last saw ^{them} him alive on 4/19/62 Death occurred at 3:00 AM 4/19/62 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T. J. FRITZLEN, M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 4-19-62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APR. 20, 1962	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY KANSAS CITY MISSOURI	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CR KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 4-20-62	26. REGISTRAR'S SIGNATURE Ruth Long

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 _____
Signature of Student Embalmer

Signed

Harold D. Quirk

Licensed Embalmer No. 4998

P. O. Address K. C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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