

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043000

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6037

VS 300
Rev. 4/59

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28 Nov 62

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. Carbaugh

USE BLACK INK OR TYPEWRITER RIBBON

FILED DEC 14 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY JACKSON		a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN OVERLAND PARK	
Length of stay in lb 3 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR 3621 WARWICK BLVD. INSTITUTION LINDEMAN-McCARTY N.H.		d. STREET ADDRESS (If outside, give location) 6904 WEST 67TH STREET	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last LOBA BELLE WATERMAN			4. DATE OF DEATH Month Day Year NOVEMBER 28 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/20/78
9. AGE (last birthday) 84		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) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (City and state or country) COLUMBUS, OHIO
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME JAMES WALLACE EBRIGHT	
13b. MOTHER'S MAIDEN NAME MARY ELLEN JOHNSON		14. NAME OF HUSBAND OR WIFE ALFRED G. WATERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ----	
17. INFORMANT MRS. GEORGE KOCH		Address 6904 WEST 67TH OVERLAND PARK, KAS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Hypostatic			INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO (b) Arteriosclerosis Splanchnic			years
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. I attended the deceased from <u>7 Dec 1960</u> to <u>28 Nov 1962</u> and last saw her alive on <u>28 Nov 1962</u>		Death occurred at <u>2:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) K.W. Carbaugh MD		22b. ADDRESS 14111 Mission Kansas	22c. DATE SIGNED 28 Nov 1962
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE NOV. 28, 1962	23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEMETERY	23d. LOCATION (City, town, or county) (State) COLUMBUS OHIO
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 11-29-62	26. REGISTRAR'S SIGNATURE Ruth Long

Dr. Donnard H. Oakes
5615 Johnson Clarke
7.36.5000

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. Reich

Licensed Embalmer No. 4998
P.O. Address X.E., 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.