

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Pittsburg

Registration District No. 668

File No. 40327

Township Sedalia

Primary Registration District No. 3032

Registered No. 331

City Sedalia (No. 412 E Boonville)

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 412 E Boonville St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

W

Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan 2 1867

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.

63

11

21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

mo

10. NAME OF FATHER

Jas. Watson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

mo

12. MAIDEN NAME OF MOTHER

Susan Jeffries

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

mo

14.

INFORMANT

(Address)

O. S. Watson

Sedalia, mo

15.

FILED

12-26-30

J. H. Love

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 23 1930

17.

HEREBY CERTIFY, That I attended deceased from 6/1-1930, to 12/23 1930, that I last saw him alive on 12/23/1930, and that death occurred, on the date stated above, at 3 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy

82

99

12-23

4

(duration) yrs. mos. ds.

CONTRIBUTORY

(SECONDARY)

Hypertension due to

(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

12/23, 1930 (Address)

apoplexy

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Crown Hill

12/25 1930

20. UNDERTAKER

ADDRESS

Gillispie

Sedalia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

100

100

100

100