

REC'D APR 17 1939

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

9533
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township Law Primary Registration District No. 1002 Registered No. 1139
(c) City N. C. Mo (d) Street No. General Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank Watson
(a) Residence, No. 14 Central & Madison Hotel St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. City Emp.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mexico
Guam

FATHER
13. NAME James Watson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT (ADDRESS) Records Dept
N. C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE 3-14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parsonica Bur
207 N. Brown

20. FILED Nov 3 1939 M. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-12-39, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-1-39, 1939, to 3-12-39, 1939.
I last saw him live on 3-12-39, 1939. Death is said to have occurred on the date stated above, at min.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset

Other contributory causes of importance:
Pulver Pneumonia Type III
Pneumococci Septal
Cerebral Type III

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify (Signed) P. J. De Maria M. D.
(Address) 517 N. Genl Hospital

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.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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, above space should be left blank.