DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36596 147

Registration District No. 963 — Primary Registration District No. — Registrar's No. 69

1. PLACE OF DEATH:
(a) County McDONALD
(b) City or town Noel
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County McDonald
(c) City or town Noel
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Columbus Smith Watson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of ~~husband~~ or wife Florence Leona Watson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2-8-1883 (Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 22 If less than one day hr. min.

9. Birthplace Marion (City, town, or county) Va. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name not known
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Sarah not known
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Florence Watson
(b) Address Noel Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof Oct 1 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Noel Mo
18. (a) Signature of funeral director Lee D Cornell
(b) Address Jonesville Mo
19. (a) Oct 9 1939 (Date received local registrar) (b) H C Alexander (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30th year 1939 hour 4:30 minute 0 M.
21. I hereby certify that I attended the deceased from July 24, 1939 to Sept 30, 1939 that I last saw him alive on Sept 30, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Hemorrhage — Duration 3 days
Due to Sarcoma R Hip
Due to Bright's Disease
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 57
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence unknown
(c) Where did injury occur? unknown (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature H L Lanning (M. D. or other)
Address Noel Mo Date signed Oct 7 1939

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

Rev. 5-17-39 — 1 X19511

RECEIVED
District Health Officer No. 6,
District File Number 1139-2137
Date Filed NOV 2 1939

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

36596
Do not use this space.

1. PLACE OF DEATH
(a) County: McDonald — Registration District No.: 963
(b) Township: Elk River — Primary Registration District No.: 5692 — Registered No.:
(c) City: — (d) Street No.: 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: Columbus Smith Watson
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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: Florence Watson

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
56	7	22	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.:
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):

FATHER
13. NAME:
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

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

17. INFORMANT (ADDRESS):

18. BURIAL, CREMATION, OR REMOVAL
PLACE: DATE: 19

19. FUNERAL DIRECTOR (ADDRESS):

20. FILED Oct 9 1939 H. C. Alexander, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 9-30, 1939

22. I HEREBY CERTIFY, That I attended deceased from 19.. to 19..
I last saw h... alive on 19.. Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

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

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) H. A. Leaming, M. D.
(Address) Noel Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.