

1939 NOV 24

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

37295
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 796

(b) Township J Primary Registration District No. 3038

(c) City Marshall (d) Street No. _____ St. _____

(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 John Watson

(a) Residence, No. 1774 W. Boyd St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

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

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

69 Unknown

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. Farm

10. Date deceased last worked at this occupation (month and year) 1939 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co. Mo.

FATHER

13. NAME John Watson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) George Watson
Marshall Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Marshall Mo DATE Oct 10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. D. Ferguson
Marshall Mo

20. FILED 10-10 1939 Mary Kent
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-7 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 1 1939 to Oct 7 1939

I last saw him alive on Oct 30 1939 Death is said to have occurred on the date stated above, at 3:00 p.m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Dec 1938

Date of onset _____

Other contributory causes of importance: ASC

Name of operation _____ Date of _____

What test confirmed diagnosis? Chronic Was there an autopsy? no

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? no

If so, specify _____ (Signed) M. J. Williams M. D.

(Address) Marshall Mo

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/18/39

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 F. D. Ferguson
Licensed Embalmer No. 2172
P. O. Address Marshall

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.