

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8001

Registration District No. MAD 22 1940

Primary Registration District No. 6018A-

Registrar's No. 351

1. PLACE OF DEATH:

(a) County St. Francois *St*
(b) City or town Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Informant at home - Employer -
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Harry Benson Watts

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nettie C. Laird Watts 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 15, 1888
(Month) (Day) (Year)

8. AGE: Years 31 Months 1 Days 23 If less than one day hr. _____ min. _____

9. Birthplace Cornwall, St. Francois Co.
(City, town, or county) (State or foreign country)

10. Usual occupation Machinest

11. Industry or business _____

12. Name Robert Watts

13. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rhodes

15. Birthplace Bullinger Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address 5215 Highland, St. Louis, Mo.

17. (a) Park View (b) Date thereof Feb. 11
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cozean Funeral Home

18. (a) Signature of funeral director [Signature]

(b) Address Farmington, Mo.

19. (a) Feb 9 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Farmington
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8
year 1940 hour 5 minute 57 P. M.

21. I hereby certify that I attended the deceased from 12-1, 1939 to Feb. 8, 1940;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma (Cancer) of Sigmoid colon Duration 14 plus months

Due to _____

Due to _____

Other conditions H/B
(Include pregnancy within 9 months of death)

Major findings: Of operations Operations at Barnes Hospt

March, '39 and Dec. '39, and

obstruction cancer found.

Later metastasis to all abdominal

22. If death was due to external causes, fill in the following: structures found.

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Sign [Signature] (Specify type of place) (City or town) (County) (State)

G. Tivis Graves, Jr. (M. D. or other) M. D.

Address Farmington, Mo. Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

MARGIN RESERVED FOR BINDING
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.

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 _____

C. H. Cozear

Licensed Embalmer No. *4084*

P. O. Address *Farmington 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8001

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 733

Primary Registration District No. 6018A

Registrar's No. _____

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Farmington, St. Francois
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Harry Benson Watts

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased Dec 15 1888
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 24 If less than one day _____ min.
51 - 1 - 23

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 15 1940 (b) T. J. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

(c) City or town _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 8
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to 1940 - 2 - 8
1888 12 - 15
51 - 1 2 - 13

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature H. J. Graves (M. D. or other) _____

Address Farmington Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

