

Registration District No. 64

Registration District No. 5100

Registrar's No. 20

FILED OCT 11 1940

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Trustee - Rural
(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 2
In this community 2
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton
(c) City or town Trustee - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME Mera C Watson

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Orvas Watson 6. (c) Age of husband or wife if alive 29 years (Month) (Day) (Year)

7. Birth date of deceased Dec. 29 - 1866

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>8</u>	<u>8</u> hr. min.

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

10. Usual occupation Wife

11. Industry or business 1

12. Name Joel C Owens

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

14. Maiden name Mary Ann Williams

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

16. (a) Informant Addie Centwiler

(b) Address Trustee Mo

17. (a) Burial (b) Date thereof 9/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trustee Cem

18. (a) Signature of funeral director J R Lintner

(b) Address Wheatland Mo

19. (a) Sept 9/1940 (b) Mrs. E. Williams
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7 year 1940 hour 3 minute 30 M.

21. I hereby certify that I attended the deceased from June 11 1940, to Sept. 7 1940 that I last saw her alive on Sept 7 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Plus Chronic Bronchitis.

Due to

Due to

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?

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

23. Signature J W Tully D.O. (M. D. or other)

Address Trustee Mo Date signed 9/7-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number

10-40-1399

Date Filed

10-8-40

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

J. R. Luckey

Licensed Embalmer No.

2982

P. O. Address

Wheatland, 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, fact should be so stated above.