

RECEIVED OCT 11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31391

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 205

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(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 2
In this community acc 2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM HADEN WATSON

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

4. Sex Male 5. Color or race W.
6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 0 years
7. Birth date of deceased Aug. 20 - 1848
(Month) (Day) (Year)

8. AGE: Years 92 Months 0 Days 24 If less than one day hr. min.

9. Birthplace Boone Co. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business
MOTHER FATHER { 12. Name James Watson
13. Birthplace Kentucky
14. Maiden name Mary Schaefer
15. Birthplace Kentucky

16. (a) Informant Maggie Gibson
(b) Address Columbia Mo.

17. (a) Burial (b) Date thereof 9-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Barbers

(b) Address Columbia Mo.

19. (a) 9/17/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 617 N. 4th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14th
year 1940 hour 4 minute 00 M.

21. I hereby certify that I attended the deceased from 4pm - 13
1940, to 9-14 - 1940
that I last saw him alive on 9-12 - 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic
1017 & conditions
chronic Duration Short

Due to gpc
Due to

Other conditions arteriosclerosis
(Include pregnancy within 3 months of death) Small

PHYSICIAN
Major findings: None
Of operations None
Of autopsy None
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) no

(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? 74

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

23. Signature W. D. Dyson (M. D. or other) 1940

Address Columbia Mo. Date signed

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

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

M. S. Whitman

Licensed Embalmer No. 3893

P. O. Address Columbia

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.