No. 2
1-13-40
-17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34827

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 1086

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital ~~or institution~~ 15 yrs 5 mo. 3 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Clair
(c) City or town Appleton City ?
(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 MATTIE WATSON
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex F
5. Color or race Col.
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife EARL WATSON
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
52	?	?	hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country) U
10. Usual occupation Housewife O
11. Industry or business A
FATHER
12. Name Dave Cooper I
13. Birthplace Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Jansine ?
15. Birthplace ? (City, town, or county) ? (State or foreign country)
16. (a) Informant Hospital Records
(b) Address State Hosp. #2 St Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-40 (Month) (Day) (Year)
(c) Place: burial or cremation Osceola Mo.
18. (a) Signature of funeral director [illegible]
(b) Address Osceola Mo.
19. (a) 10/15/40 (Date received local registrar) (b) H. Westlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12 year 1940 hour 7 minute 15 P.M.
21. I hereby certify that I attended the deceased from August 17, 1940, to Oct. 12, 1940 that I last saw her alive on Oct. 12, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 mo.
Due to ??	
Due to	
Other conditions (Include pregnancy within 3 months of death) Schizophrenia, Nefrophrenia	15 yrs

Major findings:
Of operations —
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
(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 Kenneth Thompson M.D.
Address State Hosp. #2 St Joseph, Mo. Date signed 10-15-40

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.