

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 20 1941
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14730

State File No. _____

Registration District No. 385

Primary Registration District No. 4228

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Willow Springs, Mo.
(c) Name of hospital or institution: Willow Springs, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life time /
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wagoner
(c) City or town Willow Springs, Mo.
(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 Zack Watson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 15
year 1941 hour 10 minute 30 A. M.

4. Sex M. 5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Berry Watson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 14 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 11, 1941, to April 17, 1941, that I last saw her alive on April 14, 1941, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>11</u>	<u>1</u>	hr. _____ min.

Immediate cause of death pancreatic adenocarcinoma
Due to Suppuration
Due to _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Tom Watson
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Claurinda Steavens
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Henry Watson
(b) Address Willow Springs, Mo.
17. (a) Burial (b) Date thereof 4/17/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.
19. (a) 4-17-41 (b) Darvette Ferguson
(Data received local registrar) (Registrar's signature)

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?
345
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. P. Shenoweth (M. D. or other) _____
Address Willow Springs Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 5,

District File Number 5411646

Date Filed _____

109

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 Hayd W. Ford

Licensed Embalmer No. 7910

P. O. Address 629 W Walnut

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.

Registration District No. 385

Primary Registration District No. 4229

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town Willow Springs
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Zack Watson
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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 11 1 hr. min.

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Apr day 10 year 1941 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia Duration _____
fever
infection

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

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

MISSOURI STATE BOARD OF HEALTH

11

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be supported by a valid receipt or invoice. This ensures transparency and allows for easy verification of the data.

In the second section, the author outlines the various methods used to collect and analyze the data. This includes both primary and secondary data collection techniques. The primary data was gathered through direct observation and interviews with key personnel. Secondary data was obtained from existing reports and databases.

The analysis of the data revealed several key trends and patterns. One of the most significant findings was the correlation between certain variables, which suggests a causal relationship. This insight is crucial for understanding the underlying factors that influence the outcomes.

Based on the findings, several recommendations are proposed to improve the current processes. These include implementing more robust data management systems, enhancing the training of staff, and establishing regular communication channels. These measures are expected to lead to more efficient operations and better overall performance.

In conclusion, the study has provided a comprehensive overview of the current state of affairs and offers practical solutions for addressing the identified challenges. It is hoped that these findings will be useful to the organization and contribute to its long-term success.