

FILED SEP 10 1941

Registration District No. 17Primary Registration District No. 4073

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Atchison County  
 (b) City or town Rock Port Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1 Rock Port 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 since Child. years, months or days)

8. (a) PRINT FULL NAME Jane Ellen Watson

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 26. (b) Name of husband or wife Augustus Watson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Feb. 17 1852  
(Month) (Day) (Year)8. AGE: Years 89 Months 6 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Odell County North Carolina  
(City, town, or county) (State or foreign country)10. Usual occupation House Wife

## 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Silas Clanton  
 13. Birthplace North Carolina  
 (City, town, or county) (State or foreign country)  
 14. Maiden name dolly Woodard  
 15. Birthplace North Carolina  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Spal Walter(b) Address Rock Port Mo.17. (a) Burial (b) Date thereof Aug 31 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Elmwood18. (a) Signature of funeral director J. B. Bertram(b) Address Rock Port Mo.19. (a) Dec 30 1941 (b) Mary H. Chamberlain  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison  
 (c) City or town Rock Port 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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29  
year 1941 hour 12: noon M.21. I hereby certify that I attended the deceased from Apr 24, 1941, to Aug 29, 1941;  
that I last saw her alive on Aug 29, 1941;  
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma; gall-bladder. Duration 4 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arteriosclerosis, 5 yrs  
(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 Emory H. ... M. D. or \_\_\_\_\_Address Rock Port, Mo. Date signed \_\_\_\_\_

**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 By Me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed J. B. Bertram  
Licensed Embalmer No. 4024  
P. O. Address Rock Port 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. 27676

Registration District No. 19

Primary Registration District No. 4013

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Atchison  
(b) City or town Rockford  
(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 \_\_\_\_\_  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Jane E. Watson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀

5. Color or race W

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month) (Day) (Year)

8. AGE:

Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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) \_\_\_\_\_

(Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Aug 30-41

(Date received local registrar)

(b) Mary B. Chamberlain

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_

year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_

\_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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)

(b) 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 \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

