

No. 2
9-4-41
17-39

State File No. _____

FILED APR 29 1943 69

Registration District No. _____

Primary Registration District No. 4121

Registrar's No. 2

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

1. PLACE OF DEATH

(a) County Christian

(b) City or town Bellings MD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 61 years
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME William Wathinson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced, widower 2 divorced, widower

6. (b) Name of husband or wife Thos B. Wathinson

6. (c) Age of husband or wife if alive _____ years (City, town or county) _____ (State or foreign country)

7. Birth date of deceased June 6th 1889
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Tanleton, Gloucestershire England
(City, town or county) (State or foreign country)

10. Usual occupation Jeweler

11. Industry or business _____

MOTHER FATHER

12. Name James Wathinson

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

14. Maiden name No Knowledge

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

16. (a) Informant Loebel Wathinson

(b) Address 118 E. 6th Tulsa Okla

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 43
(Month) (Day) (Year)

(c) Place: burial or cremation Rest Hill Cem

18. (a) Signature of funeral director D S Wallace

(b) Address Bellings MD

19. (a) April 2-43 (Date received local registrar) (b) Mary J. Spear (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian

(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 March day 31
year 1943 hour 8 minute 05 AM

21. I hereby certify that I attended the deceased from March 28 1943, to March 31 1943
that I last saw him alive on March 31 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Auricular fibrillation
Due to Senility

Duration 3 days
3 days

Other conditions (Include pregnancy within 3 months of death) _____

Due to 95a

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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 Charles A. Spears (M. D. or other) MD
Address Bellings Missouri Date signed 4-1-43

RECEIVED

District Health Officer No. 6,

District File Number 443-483

Date Filed APR 28 1943

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 me

working under my personal supervision.

Registered Apprentice No.

Gar Wallace Funeral Home

Signed C. J. Flayd

Licensed Embalmer No.

3527

P. O. Address

Billings, Wyo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14027
Registrar's No. 2

Registration District No. 69

Primary Registration District No. 4121

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Billings
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian
(c) City or town Billings
(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 William Robinson

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

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

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
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.....

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

SUPPLEMENTARY

MOTHER FATHER

