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X28390

Registration District No. 210

Primary Registration District No. 5466

Registrar's No. 506

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: Ozark Osteopathic Hosp.  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Wesla Mo  
Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAGGIE L.V. WATSON

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 14 years  
7. Birth date of deceased: Jan 16 1943 (Month) (Day) (Year)

8. AGE: Years 2 Months 5 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Wesla Mo (City, town or county) (State or foreign country)

10. Usual occupation Child

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

12. Name Dora Watson  
13. Birthplace Wesla Mo  
14. Maiden name Wesla Scott  
15. Birthplace Wesla Mo

16. (a) Informant Dora Watson

(b) Address Wesla Mo

17. (a) Burial (b) Date thereof June 22 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mo

18. (a) Signature of funeral director M. E. ...

(b) Address Wesla Mo

19. (a) 6-21-43 (b) S. W. Handley (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st year 1943 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 19th 1943 to June 21 1943 that I last saw her alive on 8:30 in June 21 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory collapse extension, 3rd degree  
Due to Burn of body

Duration  
5 hours  
40 hours

Due to Sitting in tub in boiling water by being pushed backward as screen door was opened.

Other conditions pushed backward as screen door was opened.

Major findings: 180-1  
Of operations: 15

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) accidental scru

(b) Date of occurrence June 9 1943

(c) Where did injury occur? Wesla Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place or in public place? Home fall into bucket boiling water

While at work? \_\_\_\_\_ (e) Means of injury Boiling water

23. Signature M. J. Hoerman (M. D. or other) MD

Address Wesla Mo Date signed 6/21/43

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

MOTHER FATHER

984

W

J. J. SE

**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, Lawrence L. Hall  
Licensed Embalmer No. 2764  
P. O. Address Wichita

**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. 128

Primary Registration District No. 5466

Registrar's No. 506

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town 5 Campbell Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: York Osteopathic Hosp  
(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 Maggie L. Watson

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

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

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 2 Months 5 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (b) S. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1945 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)

(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 \_\_\_\_\_

SUPPLEMENTARY

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

S-21393