

S. No. 2  
DM-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43332**

FILED JAN 10 1944

Registration District No. **274**

Primary Registration District No. **3052**

Registrar's No. **4307**

1. PLACE OF DEATH:

(a) County **Pettis**

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

(c) Name of hospital or institution:  
**2001 S. Ohio, St.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Forty years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **PETTIS**

(c) City or town **SEDALIA**  
(If outside city or town limits, write "RURAL")

(d) Street No. **2001 S. OHIO ST.**  
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Joseph A. Watson**

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** - day **29**  
year **43** hour **9:45** minute **14** M.

21. I hereby certify that I attended the deceased from **Dec 25**  
**1943** to **Dec 29** **1943**  
that I last saw him alive on **Dec-28** **1943**  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **Negro**

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **4 1 69**  
(Month) (Day) (Year)

Immediate cause of death **Asphyxia**  
**Edema**

Duration **4 days**

8. AGE: Years Months Days If less than one day  
**74 8 28** hr. min.

Due to **Edema**

Due to

9. Birthplace **Nashville Tenn.**  
(City, town, or county) (State or foreign country)

Other conditions **Senility, Paralysis**  
(Include pregnancy within 3 months of death)

10. Usual occupation

Major findings: **330**  
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name **Joseph Watson**

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

14. Maiden name **Don't No.**

15. Birthplace **Don't No.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Carrie Watson**

(b) Address **2001 S. Ohio, St.**

17. (a) **Burial** (b) Date thereof **1 1 44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill**

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? **1 1 44**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director **George Alexander**

(b) Address **400 W. Cooper St.**

19. (a) **12-31-43** (b) **Mrs. Anna Berger**  
(Date received local registrar) (Registrar's signature)

While at work? **118 1/2 W. Main, Sedalia**  
(Specify type of place) (e) Means of injury

23. Signature **M. W. Berger** (M.D. or other)  
Address **118 1/2 W. Main, Sedalia** Date signed **12/31/43**

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

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RECEIVED

District Health Officer No. 8

District File Number

Date Filed

1-2-44

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

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed J. J. [Signature]

Licensed Embalmer No. 4246

P. O. Address [Signature]

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.