

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

FILED - SEP 6 1944

Registration District No. 75

Primary Registration District No. 3015

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Clinton  
(b) City or town Cameron  
(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 12 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton <sup>25</sup>  
(c) City or town Cameron  
(If outside city or town limits, write "RURAL")  
(d) Street No. North Harris  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country XXXX <sup>0</sup>

3. (a) PRINT FULL NAME Pricilah E. Watson

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife R. G. Watson 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased August 12, 1854  
(Month) (Day) (Year)

8. AGE: Years 90 Months 0 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House work

11. Industry or business in home

MOTHER FATHER

12. Name Robert Cowart  
13. Birthplace Ray Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Jane Gratham  
15. Birthplace Ray Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant R. A. Watson  
(b) Address Cameron, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG 25 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Cowgill, Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address ameron, Mo.

19. (a) Aug 24 1944 Mrs. Kathleen Harris  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23rd  
year 1944 hour 8 minute 30 P M.

21. I hereby certify that I attended the deceased from Jan 10, 1942, to Aug 23, 1944,  
that I last saw her alive on Aug 23, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral  
Duration \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN \_\_\_\_\_

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address Cameron Mo Date signed 8/24/44

**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 \_\_\_\_\_

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

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. *11802*

P. O. Address. *Cameron 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Clinton  
 (b) City or town Camerson  
(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: 12 hr (Specify whether  
 in this community 12 hr 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** Prucilah E. Watson  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH Month Aug day 25 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex 7 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 \_\_\_\_\_ years  
 7. Birth date of deceased Aug. 12 1854  
(Month) (Day) (Year)

Due to Carcinoma of Uterus, right side of cervix  
 Due to \_\_\_\_\_  
 Other conditions no (Include pregnancy within 3 months of death)  
 Major findings: no Of operations  
 Of autopsy no

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day min. \_\_\_\_\_  
 9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 Had \_\_\_\_\_  
**PHYSICIAN** \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
**MOTHER** { 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) \_\_\_\_\_  
(Date 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?  
 While at work? \_\_\_\_\_ (Specify type of work)  
 23. Signature M. Lester (M.D. or other)  
 Address \_\_\_\_\_ (City or town) (County) (State)

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

SUPPLEMENTARY INFORMATION REQUESTED

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