

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2232 No 7th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 yrs
years, months or days

3. (a) PRINT FULL NAME Charles Clifford Watson

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 Married
6. (b) Name of husband or wife Stella 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 17 1882
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 10 If less than one day
hr. _____ min. _____

9. Birthplace Bloomville Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Theater Mgr

11. Industry or business _____

12. Name Charles S. Watson

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

14. Maiden name Emma C

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

16. (a) Informant Stella Watson

(b) Address St Joseph, MO

17. (a) Burial (b) Date thereof 11-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph Mo

19. (a) 11-29-44 (b) Zelen J Decker
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2232 No 7th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1944 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 5-44
19____ to Nov 27 19____
that I last saw him alive on Nov 27 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of skull and brain Duration 6 mo

Due to _____

Due to _____

Other conditions 5 4 1/2
(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) no

(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 H. G. Kearney (M. D. or other) M.D.

Address St Joseph Mo Date signed 11-27-44

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

JAN 10 1945

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 _____

working under my personal supervision. _____ Registered Apprentice No. _____

Signed Robert H. Yapple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.