

5. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40524

FILED DEC 22 1944

Registration District No. 2

Primary Registration District No. 4011

Registrar's No. \_\_\_\_\_

006

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

1. PLACE OF DEATH:

(a) County ATCHISON  
 (b) City or town WATSON - nicholston  
 (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 \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Atchison  
 (c) City or town Watson  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM MELTON SUGG.

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 WIDOWED  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 4-6-1867  
 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 6  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation retired

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

MOTHER FATHER  
 12. Name GREEN SUGG  
 13. Birthplace UNKNOWN 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN  
 15. Birthplace \_\_\_\_\_ 7  
 (City, town, or county) (State or foreign country)

16. (a) Informant Ethel W. Wolf  
 (b) Address Watson

17. (a) BURIAL (b) Date thereof 12-15-1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD

18. (a) Signature of funeral director Burchell Mortuary  
 (b) Address Rock Port, Mo

19. (a) 12-14-44 (b) J. A. Gray  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 12th  
 year 1944 hour 8.00 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 1-, 1944, to Dec 11, 1944;  
 that I last saw him alive on Dec 10th, 1944;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition- 10 Yrs  
 Duration  
 Due to Chronic Dysentery.

Due to Ameba-

Other conditions Hernia & Prolapse rectum  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations 270  
 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 James A. Gray (M. D. 12/11/44)  
 Address Watson Mo. Date signed \_\_\_\_\_

**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 *Geoff Bartholomew*  
Licensed Embalmer No. *3173*  
P. O. Address *Rock Port. 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.**