

FILED JUN 19 1945

Registration District No. 332

Primary Registration District No. 4494

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Winona, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution No (Specify whether
In this community 2 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon
(c) City or town Winona, Mo 101
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Charles H. Watson

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mabel L. Watson 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Dec. 2nd 1900
(Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Cheese Maker

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin F. Watson
13. Birthplace Texas
(City, town, or county) (State or foreign country)
14. Maiden name Dallas Brown
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Mabel Lee. Watson
(b) Address Winona, Mo
17. (a) Burial (b) Date thereof 5/19 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Chappell

18. (a) Signature of funeral director _____
(b) Address Mountain View, Mo
19. (a) 5-14-45- (b) Frank Hyde M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th
year 1945 hour 8 minute 30 a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations III
Of autopsy _____

Duration _____
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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Frank Hyde (M. D. or other) D
Address Excimer Date signed 5-18-45

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

RECEIVED

District Health Officer No. 5,

District File Number 645298

Date Filed 6-16-45

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 John F. Duncan
Licensed Embalmer No. 2516
P. O. Address Mountain View 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.