

FILED AUG 9 1945

Registration District No.

Primary Registration District No. 3020

State File No.

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Franklin.

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

(c) Name of hospital or institution:  
307 Stafford St. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None. (Specify whether  
In this community 50 yrs. years, months or days)

3. (a) PRINT FULL NAME Malsine W. Watermann.

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband Henry F. Watermann. 6. (c) Age of husband deceased if alive deceased years

7. Birth date of deceased February 15th, 1879  
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 9 If less than one day  
hr. min.

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

10. Usual occupation International Shoe Co.

11. Industry or business X

12. Name William Dierking.

13. Birthplace Enroute to America.  
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Duwendack.

15. Birthplace Unknown, Germany.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ottilie Viehe

(b) Address Washington, Missouri.

17. (a) Burial (b) Date thereof July 27, 1945.  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Nielburg & Voth, Inc.

(b) Address Washington, Mo.

19. (a) 7/25/45 (b) Leuel R. Brook  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. 307 Stafford St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th.  
year 1945 hour 1:00 minute 45 P.M.

21. I hereby certify that I attended the deceased from JUNE 22 1945 to JULY 24 1945  
that I last saw him alive on JULY 24 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage. Duration 4 hrs.

Due to don't know

Due to " "

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 63W

Of autopsy

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) (c) Means of injury

23. Signature E. J. Turner (M.D. or other) P.O.

Address Washington Mo. Date signed 7/25/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-8-45

NOV 21 1945

NOV 23 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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Lester H. Velt*

Licensed Embalmer No.

*3254*

P. O. Address

*Washington, Md*

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.