

FILED AUG 5 1946
Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 127

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Marshall**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Fitzgibbons Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days** (Specify whether
In this community **3 Years** years, months or days)

3. (a) PRINT NAME **Mary Ann Deaton Watts**

3. (b) If veteran, name war. 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Lester Watts** 6. (c) Age of husband or wife if alive **30th, 1876**
7. Birth date of deceased (Month) **October** (Day) **30th** (Year) **1876**

8. AGE: Years **69** Months **8** Days **23** If less than one day hr. min.

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

10. Usual occupation **None**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown** 9
13. Birthplace **Unknown** 1
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown** 4
15. Birthplace **Unknown** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs W. H. Wood**
(b) Address **875 S-Redman, Marshall, Mo.**

17. (a) **Burial** (b) Date thereof **July 25, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Arrow Rock, Mo.**

18. (a) Signature of funeral director **Charles R. Rums**
(b) Address **Marshall Mo.**

19. (a) **7-27-46** (b) **Mrs T. W. Wood**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline** 97
(c) City or town **Marshall** 2
(If outside city or town limits, write "RURAL")
(d) Street No. **875 South Redman** 7
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **23** day **July**
year **1946** hour **8** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Jan 1946** to **July 23, 1946**
that I last saw him alive on **July 23, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death. **Coronary Thrombosis** 8244

Due to **Pericarditis** 18 7407

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **none** 938

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) (a) Means of injury

23. Signature **R. W. Wood** (M. D. or other)
Address **Marshall Mo.** Date signed **7-24-46**

RECEIVED

District Health Officer No. 8

District File Number 1-3-46

Date Filed 1-3-46

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 W. Campbell Jr.
Licensed Embalmer No. 3419
P. O. Address Marshall, N.C.

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.