. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1946

Registration District No. 25

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37834

Primary Registration District No. 3048

Registrar's No. 165

1. PLACE OF DEATH:

(a) County NODAWAY

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

(c) Name of hospital or institution:
MARTIN LANDFATHER HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 HRS (Specify whether
In this community 25 hrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County North 113

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

(d) Street No. ✓
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME ORLA BARKMAN WATSON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M O

5. Color or race W

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

6. (b) Name of husband or wife Elizabeth Irene Watson

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased 11 (Month) 28 (Day) 1899 (Year)

8. AGE: Years 46 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation Druggest

11. Industry or business Drug Store

FATHER
12. Name Willis Coleman Watson
13. Birthplace North Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Della Barkman
15. Birthplace Sheridan (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Elizabeth Watson
(b) Address Sheridan Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (Month) (Day) (Year)
(c) Place: burial or cremation Sheridan Cem.

18. (a) Signature of funeral director Arch C Dunfee
(b) Address Grant City, Mo.

19. (a) Nov 9 1946 (Date received local registrar) (b) Bess Balt. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 1
year 1946 hour 8 minute 50 P.M.

21. I hereby certify that I attended the deceased from Oct 31, 1946, to Nov 1, 1946
that I last saw him alive on Nov 1, 1946;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Fracture of Skull	26 HRS
LACERATION OF BRAIN	26 HRS
Due to AEROPLANE CRASH, WITH LIGHTPOLE ON ATTEMPTED LANDING	
Due to DARKNESS	
Other conditions DISLOCATION RT. HIP (Include pregnancy within 3 months of death)	26 HRS

Major findings:
Of operations
Of autopsy 173.6 34

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) ACCIDENT 113

(b) Date of occurrence

(c) Where did injury occur? SHERIDAN, WORTH, MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
FARM (Specify type of place)
While at work? NO (e) Means of injury AEROPLANE CRASH WITH GROUND

23. Signature W. L. Landfather (M. D. or other) D.O.
Address MARYVILLE MO. Date signed 11-1-46

229 (Licensed Embalmer's Statement on Reverse Side)

FEB 3 1947

FEB 7 1947

NOV 1 1943

DEC 2 1948

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.

DISTRICT HEALTH OFFICE
Cameron, Mo.

Signed Jack C. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.