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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 5 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
Registration District No. 42 Primary Registration District No. 1000  
Registrar's No. 136

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

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
709 1/2 So. 10th. 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 27 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 1/2 So. 10th. St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \*

3. (a) PRINT FULL NAME William Asa Watson  
3. (b) If veteran, name war None  
3. (c) Social Security No. 493-14-6174

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Corina R. Watson  
6. (c) Age of husband or wife if alive 51 years  
7. Birth date of deceased December 12 1889  
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 13  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Sign Painter

11. Industry or business Gordon Sign Co.

MOTHER FATHER

12. Name Oliver S. Watson  
13. Birthplace Terra Haute Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Mathilda Swanson  
15. Birthplace Unknown Sweden  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth Watson  
(b) Address 709 1/2 So. 10th. St.

17. (a) Burial (b) Date thereof Jan. 28, 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Norman W. Sidusaden  
(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 1-30-47 (b) E. B. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25  
year 1947 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from  
Oct 26, 1946 to Jan 25, 1947.  
that I last saw him alive on Jan 24, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Myocardial Degeneration  
Atrial Fibrillation  
Due to Arteriosclerosis general  
Coronary Thrombosis  
Due to Lucid Intermittent

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 306

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 W. Jenkins M.D. (M. D. or other)  
Address St. Joseph Mo. Date signed 1-27-47

PHYSICIAN  
Underline the cause to which death should be charged statistically.

MAR 1 9 1947

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**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..... *Ernest Thomas* .....

Licensed Embalmer No. *2640* .....

P. O. Address *St Joseph M* .....

**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.**