

No. 2
12-45
17-39
147070

FILED MAR 28 1947

Primary Registration District No. **2001**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1309 North St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **49**
(c) City or town **Joplin** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **1309 North St** **5**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **Celestine Sarah Watson**

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

4. Sex **Female** 5. Color or race **Black** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **William Watson** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 6 1877**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	10	12	hr. _____ min. _____

9. Birthplace **Bayou Rouge Louisiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Roy Sandy** **9**
13. Birthplace **No Record** **1**
(City, town, or county) (State or foreign country)

14. Maiden name **No Record** **9**
15. Birthplace **No Record** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elmira Watson**

(b) Address **1309 N. St Joplin Mo**

17. (a) **Removal** (b) Date thereof **Beegs & Kea**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hurlbut Und. Co**

18. (a) Signature of funeral director _____
(b) Address **Joplin Mo.**

19. (a) **3-12-47** (b) **Ed James**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **18th**
year **1947** hour **9:00** minute _____ A. M.

21. I hereby certify that I attended the deceased from **February 17**
1947 to **February 17** 19 **47**
that I last saw her alive on **February 17** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, left upper lobe** Duration **2 days**

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline any 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? **0**

(e) Means of injury _____
While at work? _____ (Specify type of place)

23. Signature **Eugene H. James** or other **M.D.**
Address **325 2nd St** Date signed **2-19-47**
Joplin, Mo

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

47-3-182

571
—M
102

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 156 Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Celestine S. Watson

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased April 6 (Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days _____ (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Lobar Pneumonia Duration 2 days

Due to _____

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Ernest H. Hamilton (M. D. or other) _____
Address Joplin, Mo. Date signed 4-7-47

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

SUPPLEMENTARY

9676