

No. 2  
1-5-43  
5-17-39  
I X36871

FILED SEP 5 1947

Registration District No. 70.0 Primary Registration District No. 3018 Registrar's No. 58

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

1. PLACE OF DEATH:

(a) County DENT

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

(c) Name of hospital or institution:  
NONE  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DENT <sup>33</sup>

(c) City or town SALEM <sup>5</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY L. WATSON

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

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased SEPT 2 1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 9  
year 1947 hour 3:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>11</u>	<u>2</u>	hr. _____ min. _____

Immediate cause of death Thermic Fever <sup>Duration 4-5 days</sup>

Due to Excessive Heat wave

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace CRAWFORD Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name FERRIL MANCHE

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

14. Maiden name MELINDA EARNEY

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

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 G. E. Graft (M. D. or other) \_\_\_\_\_  
Address Salem, Mo. Date signed 8/6/47

16. (a) Informant M. Watson

(b) Address SALEM, MISSOURI

17. (a) BURIAL (b) Date thereof 8/6/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pinto, Cem.

18. (a) Signature of funeral director Carl K. Spencer

(b) Address SALEM, MISSOURI

19. (a) 8-8-47 (b) M. M. Holt, M.D.  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Office No. 5,

District

84-7485

Date Filed

8-30-47

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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 *Wm. W. McDonald*

Licensed Embalmer No. *3806*

P. O. Address *Salem, Me.*

**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.