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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1947
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 2000

State File No. 30958
Registrar's No. 824A

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Baptist Hosp.
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 2 Hrs. (Specify whether
In this community 2 Hrs. (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Dale Gene Watts
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept. 18 1947
(Month) (Day) (Year)

8. AGE: Years — Months — Days — If less than one day 2 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Homer Watts
13. Birthplace Marshall Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Ethel Watkins
15. Birthplace Bolivar Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Homer Watts
(b) Address Bolivar, Mo.

17. (a) Burial (b) Date thereof 9/19/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bolivar, Mo.

18. (a) Signature of funeral director Erwin & Blue
(b) Address Bolivar, Mo.

19. (a) 9-19-47 (b) W E Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Polk
(c) City or town Bolivar
(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 Sept. day 18
year 1947 hour 7 minute 13a. M.

21. I hereby certify that I attended the deceased from 18 Sept '47 @ 5:15 AM, 19 to 18 Sept '47 @ 7:13 AM
that I last saw him alive on 18 Sept 1947, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration _____

Due to congenital absence of diaphragm on left and patent ductus arteriosus

Due to _____

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

Major findings: 15
Of operations _____
Of autopsy congenital absence of left diaphragm
abdominal viscera in thorax
patent ductus arteriosus

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 John Robrien M.D.
Address Bolivar, Mo. Date signed 18 Sept 47

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

MOTHER FATHER

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.....

This body was not embalmed.

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.