

No. 2
1/47
5-17-39

40944

FEDERAL SECURITY AGENCIES

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics
FILED JAN 3 1949 255

Registration District No.

Primary Registration District No. 5875

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Shawsville Mo
(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 9 mos (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Oregon

(c) City or town Shawsville
(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 Kate Edla Watson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 20 year 1948 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 18 1948 to August 20 1948
that I last saw her alive on August 18 1948
and that death occurred on the date and hour stated above.

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 Nov 2 - 1867
(Month) (Day) (Year)

Immediate cause of death Myocarditis

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>9</u>	<u>18</u>	hr. _____ min.

9. Birthplace De Kalb, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation News-wiper

11. Industry or business _____

12. Name Chas. F. Neelis

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

14. Maiden name Mrs. Richard

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

16. (a) Informant Maggie Peckert

(b) Address Shawsville, Mo

17. (a) B. (b) Date thereof 8-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shawsville

18. (a) Signature of funeral director Robertson

(b) Address Shawsville Mo

19. (a) 1-10-49 (b) Mrs. W. C. Johnson
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause of 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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature R. D. Davis (M. D. or other) _____

Address Burch Tree Mo Date signed 9/10-48

DR Davis

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

MOTHER FATHER

RECEIVED 12-27-48
District Health Officer No. 5,
District File Number 1348994
Date Filed 12-27-48

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. 255 Primary Registration District No. 5875

1. PLACE OF DEATH: Oregon
(a) County _____
(b) City or town Thammasully
(If outside city or town limits, give "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)

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 _____

3. (a) PRINT FULL NAME Kate E. Watson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 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 Jan 2 (Month) (Year)

8. AGE: Years 80 Months 9 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 _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
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) 1-10-49 (b) M. W. Johnson
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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) (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-40944