

FILED FEB 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1754

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BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 152

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY OR TOWN Mount Vernon		c. CITY OR TOWN Silex	
c. LENGTH OF STAY (In this place) 180 da		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri State Sanatorium			
3. NAME OF DECEASED (Type or Print) a. (First) Joe b. (Middle) Alexander c. (Last) Watts			4. DATE OF DEATH (Month) (Day) (Year) Jan 20 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7-10-20
9. AGE (In years last birthday) 28		10. UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	11. BIRTHPLACE (State or foreign country) Silex, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman & Bus driver-Automobile		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Norton B. Watts		13b. MOTHER'S MAIDEN NAME Mary Campbell	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 489-12-5100	17. INFORMANT'S SIGNATURE OR NAME E. McMichael, Record Clerk ADDRESS Mo. State Sanatorium, Mt. Vernon, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH Abt. 6 yrs.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Respiratory failure - Post operative, following Right pneumonectomy.			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 1-19-49	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) SILEX (COUNTY) Lincoln (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 0	
22. I hereby certify that I attended the deceased from July 25, 1948 , to Jan 20, 1949 , that I last saw the deceased alive on Jan 20, 1949 , and that death occurred at 4:45p m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) C. A. Brasler M.D.		23b. ADDRESS Mount Vernon, Missouri	23c. DATE SIGNED 1-20-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-21-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Silex Mo
DATE REC'D BY LOCAL REG. 1-21-49	REGISTRAR'S SIGNATURE Cecil Hendricks	411	25. FUNERAL DIRECTOR'S SIGNATURE Max L. Tossell ADDRESS

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

RECEIVED
District Health Officer No. _____
District File Number 149-117
Date Filed 1-31-49

MAR 4 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Max L. Fossett

Licensed Embalmer No. H 282

P. O. Address Wilmington, Mo.

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.