

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7555

State File No.

BIRTH NO.		REG. DIST. NO. <u>43</u>	PRIMARY REG. DIST. NO. <u>3007</u>	Registrar's No. <u>109</u>
1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>DUNKLIN</u>		
b. CITY OR TOWN <u>Poplar Bluff</u> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <u>Clarkton - Freeborn Twp</u> (If outside corporate limits, write RURAL and give township)		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Doctor's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. 1</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Almus</u>		b. (Middle) <u>Earl</u>		c. (Last) <u>Watson</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>March 20 1949</u>		5. SEX <u>Male</u>		
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 29, 1910</u>
9. AGE (In years last birthday) <u>38</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>D. H. Watson</u>		
13b. MOTHER'S MAIDEN NAME <u>Nora Keel</u>		14. NAME OF HUSBAND OR WIFE <u>Alma Watson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Almus Watson</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		17. ADDRESS <u>Clarkton Mo. R. 1</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure Acute</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Myocardial insufficiency</u>		
DUE TO (c) <u>Rheumatoid Cardiac Enlg.</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>H222</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>March 12, 1949</u> , to <u>March 20, 1949</u> , that I last saw the deceased alive on <u>March 20, 1949</u> , and that death occurred at <u>3:30 p.m.</u> from the causes and on the date stated above.				
23a. SIGNATURE <u>Ed Markel M.D.</u>		(Degree or Title)		23b. ADDRESS <u>Poplar Bluff Mo.</u>
23c. DATE SIGNED <u>3-24-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
24b. DATE <u>Mar. 22 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead</u>		24d. LOCATION (City, town, or county) (State) <u>Clarkton Mo. R. 1</u>
DATE REC'D BY LOCAL REG. <u>3/25/49</u>		REGISTRAR'S SIGNATURE <u>A. H. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bandess Funeral Home</u>
				ADDRESS <u>Campbell, Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

12
7
3

APR 11 REC'D

BUTLER COUNTY HEALTH CENTER
PO BOX 2111, BUTLER, MISSOURI

449-52

4-11-49

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.

Signed.....

Christina M. Landess

Signed.....

Student Embalmer

Licensed Embalmer No. *4227*

P. O. Address.....

Campbell, 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.