

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7901**

BIRTH NO. _____ REG. DIST. NO. **98** PRIMARY REG. DIST. NO. **4165** Registrar's No. **36**

1. PLACE OF DEATH a. COUNTY Daviess		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Daviess	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gallatin		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gallatin	
c. LENGTH OF STAY (in this place) 23 Yrs		d. STREET ADDRESS (If rural, give location) ---	
d. FULL NAME OF HOSPITAL OR INSTITUTION ---			

3. NAME OF DECEASED (Type or Print)	a. (First) Kitty	b. (Middle) Melvina	c. (Last) Watson	4. DATE OF DEATH (Month) (Day) (Year) March 21 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 30 1881	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 11	IF UNDER 1 YEAR Days 21	IF UNDER 1 MIN. Hours ---	IF UNDER 1 MIN. Min. ---
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Big Springs, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Noah Hart	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Robert Lee Watson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME N. L. Watson	ADDRESS Gallatin, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cholecystitis		5 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis		3 yrs
DUE TO (c) Arterial Regeneration		3 yrs	
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 585A	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Gallatin Daviess Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 **1838**, to **Mar 21, 1949**, that I last saw the deceased alive on **Mar. 21, 1949**, and that death occurred at **7 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Floyd E. Nelson M.D.	23b. ADDRESS Gallatin Mo	23c. DATE SIGNED 3-24-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-24-49	24c. NAME OF CEMETERY OR CREMATORY Brown Cemetery	24d. LOCATION (City, town, or county) (State) Gallatin, Mo.
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DATE REC'D BY LOCAL REG. 25 March 1949	REGISTRAR'S SIGNATURE Virginia M Engler	25. FUNERAL DIRECTOR'S SIGNATURE L. D. Dickerson	ADDRESS Hope Funeral Home Gallatin, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed

L. O. Richesson

Licensed Embalmer No. *3302*

P. O. Address *Fall River, Mass.*

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.