

10
00
048

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Griffith 22559
State File No.

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 5120 Registrar's No. 184

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Columbia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Columbia</u>	
c. LENGTH OF STAY (In this place) <u>3 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D.#4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>X R.F.D.#4</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>WATSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 4, 1895</u>	9. AGE (In years last birthday) <u>53</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Kingston, Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>Joseph Watson</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Kopske</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Onesky Watson</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>333-03-6229</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mary Watson R.F.D.#4 Columbia, Mo.</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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>239A</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain tumor, glioma</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

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) _____
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 Jan 15, 1949 to July 16, 1949, that I last saw the deceased alive on July 14, 1949, and that death occurred at 3 1/2 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Harry W. Griffith, M.D.</u>	23b. ADDRESS <u>Columbia, Mo.</u>	23c. DATE SIGNED <u>July 18, 1949</u>
---	-----------------------------------	---------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 19, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>
---	--------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>July 18 1949</u>	REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parber Funeral Service Columbia Mo.</u>
--	---	---

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

RECEIVED
JUL 26 1919
District Health Officer No. 9,
District File Number

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4067

P. O. Address Columbia Md

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.