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

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30924

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>171</u>		PRIMARY REG. DIST. NO. <u>4267</u>		Registrar's No. <u>13</u>	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Washington Rural</u>		c. LENGTH OF STAY (In this place) <u>54</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mayfield</u>		54	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>R</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carol</u>		b. (Middle) <u>Eunice</u>		c. (Last) <u>Watson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-3-49</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>Oct 31-1947</u>	
9. AGE (In years last birthday) <u>21</u>		10. USUAL OCCUPATION: (Give kind of work done during most of working life, even if retired) <u>ml</u>		11. BIRTHPLACE (State or foreign country) <u>Mayfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION: (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Cecil Leroy Watson - Sibel Bradford</u>			13b. MOTHER'S MAIDEN NAME <u>Mayfield</u>			14. NAME OF HUSBAND OR WIFE <u>Mayfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>770</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>Fracture skull & brain laceration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Playing in family car</u> <u>shifted gear car coasted.</u> DUE TO (c) <u>Fell from car</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Wheel landed over head</u>				INTERVAL BETWEEN ONSET AND DEATH <u>22:24</u> <u>25</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mayfield Lafayette Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 3-1949 7P m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>motor car wheel struck over head</u>			
22. I hereby certify that I attended the deceased from <u>Called at home</u> , that I last saw the deceased alive on <u>7P m.</u> , 19 <u>49</u> , and that death occurred at <u>7P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. J. Martin M.D. Coroner</u>				23b. ADDRESS <u>1503 O.essa Mo</u>		23c. DATE SIGNED <u>8-3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-5-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>city cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Pigginsville Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-5-1949</u>		REGISTRAR'S SIGNATURE <u>Letta Drummond</u>		5. FUNERAL DIRECTOR'S SIGNATURE <u>1503</u>		ADDRESS <u>Pigginsville</u>	

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RECEIVED

SEP 2

District Health Officer No. 8,

District File Number _____

Date Filed 9-16-49

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 Forrest S. Hooper

Signed _____
Student Embalmer

Licensed Embalmer No. 4358

P. O. Address Jigginsville, Va.

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.