

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34315

State File No. _____

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BIRTH NO. _____ REG. DIST. NO. 180 PRIMARY REG. DIST. NO. 4292 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Winfield		c. LENGTH OF STAY (in this place) 3 yr.	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Winfield	
		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Elizabeth	b. (Middle) (Frey)	c. (Last) Watts	4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 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 Dec. 29, 1888	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Shelbyville, Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Gordon Watts
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Fred Matthews ADDRESS Detroit, Mich.
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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, asthenia, 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) Carcinoma of liver	DUE TO (b) Sclerotic heart disease	10 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c)		14 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			15 1/2 A

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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?
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22. I hereby certify that I attended the deceased from June, 1948, to Oct. 17, 1949, that I last saw the deceased alive on Oct. 15, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. H. F. Kelley D.O.	23b. ADDRESS Winfield Mo.	23c. DATE SIGNED 10-19-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE Oct. 21, '49	24c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	24d. LOCATION (City, town, or county) (State) Belleville, Illinois
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DATE REC'D BY LOCAL REG. 10-21-49	REGISTRAR'S SIGNATURE J. S. Neunhite	FEDERAL DIRECTOR'S SIGNATURE Stalder	ADDRESS Elsberry, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1949
NOV 23 1949

District File Number

District Health Officer No. 9,

RECEIVED OCT 24 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 _____

Licensed Embalmer No. 40126

P. O. Address. Elsberry, 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.