

FILED FEB 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2092

BIRTH NO. _____ REG. DIST. NO. 282 PRIMARY REG. DIST. NO. 3055 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give town) Bolivar		c. CITY (If outside corporate limits, write RURAL and give township) Bolivar	
c. LENGTH OF STAY (in this place) 43 years		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Scroggins Rest Home			

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Webster	c. (Last) Watson	4. DATE OF DEATH (Month) (Day) (Year) Jan. 29, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH August 14, 1868	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired watch maker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David C. Watson	13b. MOTHER'S MAIDEN NAME Mary A. Shipley	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Hattie Cherrington	ADDRESS Bolivar, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gangrene of leg & foot		INTERVAL BETWEEN ONSET AND DEATH 450!
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Gangrene of leg. Amputation	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 Jan 19, 1950, to Jan 28, 1950, that I last saw the deceased alive on Jan 27, 1950, and that death occurred at 5:30a m., from the causes and on the date stated above.

23a. SIGNATURE D. G. M. Crow (Degree or title) M.D.	23b. ADDRESS Bolivar, Mo.	23c. DATE SIGNED 1-30-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Jan. 31, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) Bolivar, Mo. (State)
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DATE REC'D BY LOCAL REG. Jan 30, 1950	REGISTRAR'S SIGNATURE Ralph Gordon	25. FUNERAL DIRECTOR'S SIGNATURE Tur pin Funeral Home	ADDRESS Bolivar, Mo.
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(Licensed Embalmer's Signature on Reverse Side)

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

841
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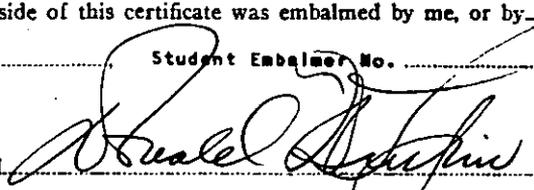
RECEIVED
District Health Officer No. 7,
District File Number 1-50-38
Date Filed 2-7-50

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
Student Embalmer

Signed  _____
Student Embalmer No. _____

Licensed Embalmer No. 3053

P. O. Address Bolivar, 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.