

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11105

State File No. ....

FILED APR 11 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6065 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Clair</u> <u>1930</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Osceola</u> (Rural)		c. LENGTH OF STAY (in this place) <u>6 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Osceola</u> (Rural) <u>Polk</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>10-Miles E* Osceola</u>			d. STREET ADDRESS (If rural, give location) <u>Polk Township Osceola-St. Clair</u>		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Leon</u>	b. (Middle) <u>Gates</u>	c. (Last) <u>Watson</u>	(Month) <u>Mar</u>	(Day) <u>29</u>	(Year) <u>1953</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct; 20, 1900</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MRS. Hours	IF UNDER 1 MRS. Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Fayette Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		

13a. FATHER'S NAME <u>Elmer Watson</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Flora Watson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>#95-03-3735</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Flora Watson, Osceola Mo.</u>	ADDRESS
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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) <u>Suicide</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gun Shot Wound Self Inflicted</u> 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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Osceola, Polk Twp, St. Clair Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Mar, 29, 1953</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Gun Shot self inflicted</u>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 6: A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Loretta B. Goodrich</u>	(Degree or title)	23b. ADDRESS <u>Osceola Missouri</u>	23c. DATE SIGNED <u>3/30/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-1-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>4-8-53</u> <u>Paul Seever</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Goodrich</u>	ADDRESS <u>Osceola Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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3-80-53

MAY 6 1971

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 \_\_\_\_\_

*J. B. [Signature]*

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.