

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24004**

FILED AUG 10 1953		REG. DIST. NO. <b>42</b>	PRIMARY REG. DIST. NO. <b>1000</b>	Registrar's No. <b>858</b>
1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. LENGTH OF STAY (In this place) <b>life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>DeKalb</b> <b>0110</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>		
3. NAME OF DECEASED (Type or Print) <b>Lenora</b>		a. (First)	b. (Middle)	c. (Last) <b>Watson</b>
4. DATE OF DEATH <b>July 29, 1953</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>May 18, 1880</b>		9. AGE (In years last birthday) <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>DeKalb, Missouri</b> <b>0</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>James Reagan</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Collins</b>
14. NAME OF HUSBAND OR WIFE <b>William M. Watson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT'S SIGNATURE OR NAME <b>Miss Mamie Watson, DeKalb, Missouri</b>		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.		19. INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Congestive Heart Failure</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Heart Disease</b>		<b>unknown</b>
DUE TO (c) <b>Hypertension</b>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>unknown</b>
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 <b>July 27, 1953</b> , to <b>July 29, 1953</b> , that I last saw the deceased alive on <b>July 29, 1953</b> , and that death occurred at <b>5:40 a. m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Sharon E. Waggoner M.D.</b>		23b. ADDRESS <b>301 Illinois Ave. St. Joe.</b>		23c. DATE SIGNED <b>7-30-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>7/31/1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Westlawn Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>DeKalb, Missouri</b>		DATE REC'D BY LOCAL REG. <b>Aug. 6, 1953</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>
25. FUNERAL DIRECTOR'S SIGNATURE <b>Sharon E. Waggoner</b>		ADDRESS <b>St. Joseph, Mo.</b>		(Licensed Embalmer's Statement on Reverse Side)

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

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 William J. Galding

Licensed Embalmer No. 4535

P. O. Address 319 S. 11th St. St. Joseph, 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.