

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32414**

FILED **SEP 21 1953**

BIRTH NO. **62370** REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **321**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ball	
b. CITY OR TOWN Hannibal		c. CITY OR TOWN New London #870	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) EDWARD c. (Last) WATSON			4. DATE OF DEATH (Month) (Day) (Year) SEPT 9 1953
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH SEPT 8-1953
9. AGE (In years last birthday) 1 day		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	11. BIRTHPLACE (State or foreign country) Hannibal, Mo
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY -	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME GEORGE COOK WATSON		13b. MOTHER'S MAIDEN NAME RUTH MILLER	14. NAME OF HUSBAND OR WIFE -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mrs Geo. Watson ADDRESS New London Mo.
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary atelectasis INTERVAL BETWEEN ONSET AND DEATH 1 day ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anoxia - 1 day	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7620	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 9/8/1953 to 9/9/1953 , that I last saw the deceased alive on 9/9/1953 and that death occurred at 7 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Robert J. Lanning M.D.		23b. ADDRESS Hannibal, Mo	
23c. DATE SIGNED 9/9/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept 10-1953	
24c. NAME OF CEMETERY OR CREMATORY Burkley Cem.		24d. LOCATION (City, town, or county) (State) New London Mo	
DATE REC'D BY LOCAL REG. 9-11-53		REGISTRAR'S SIGNATURE Dr. E.M. Lucke By W. Fisher	
25. FUNERAL DIRECTOR'S SIGNATURE J. Fields and Son		ADDRESS Frankford Mo	

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

RECEIVED SEP 17 1952
MARION CO. HEALTH DEPT.
DATE FILED SEP 17 1952

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 Joe Fields Megaw

Licensed Embalmer No. 4093

P. O. Address Frankford 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.