

FILED MAY 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
16784

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 475

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. St. John's Hosp.		Length of stay in lb s 10 Yrs	d. STREET ADDRESS (If outside, give location) 2419 S. Golden Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) CRAIG WATTS First Middle Last			4. DATE OF DEATH May 16 1957 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24 1945		9. AGE (In years last birthday) 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Marengo, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Dr. C.F. Watts			14. MOTHER'S MAIDEN NAME Helen White		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs. Helen Watts Springfield, Mo. Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEAD AND CHEST INJURIES		INTERVAL BETWEEN ONSET AND DEATH INST.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) STRUCK BY AUTOMOBILE ON CITY STREET AND ALSO A STATE U.S. HIGHWAY (2300 BLOCK W. SUNSHINE)		
20c. TIME OF INJURY 8:20 P.M. Hour Month, Day, Year May 16 1957			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) STREET		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE SPRINGFIELD, GREENE, MISSOURI		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at About 8:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) Ralph H. Lohmeyer Coroner			22b. ADDRESS Springfield Missouri		22c. DATE SIGNED 21/May/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/18/57	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Mo.	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 5-21-57	26. REGISTRAR'S SIGNATURE Emilia Williamson

(Licensed Embalmer's Statement on Reverse Side)

300
1-56
All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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:
Signature of Student Embalmer

Signed *H. J. McCann*

Licensed Embalmer No. *274*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.