

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014938
STATE FILE NUMBER

FILED APR 24 1958

Registration District No. 187 Primary Registration District No. 5700 Registrar's No. 119

300
1-57
590

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> ^(pop) <u>0590</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grand River Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Grand River Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grand River Twp.</u>		Length of stay in 1b <u>25 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Grand River Twp.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH RUELDA WATSON</u>			4. DATE OF DEATH Month Day Year <u>April 12 1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1890</u>	9. AGE (In years last birthday) <u>67</u>	IF FUNDER 1 YEAR Months Days Hours Min.	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) <u>Home Maker</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sumner, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Oscar M. Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Matilda Harsh</u>	14. NAME OF HUSBAND OR WIFE <u>Carl 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>NONE</u>	17. INFORMANT <u>Alva Watson; Avalon, Missouri</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>9160</u> <u>16</u>
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"/>

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.) <u>House caught on fire + Patient burnt up</u>
20c. TIME OF INJURY <u>1:00</u> p.m. Hour Month, Day, Year <u>4-12-58</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Avalon, Livingston, Mo</u> COUNTY <u>0591</u> STATE
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21. I attended the deceased from None to 7:30/A and last saw her alive on Apr. 12-58
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph A. Conrad M.D. (COTONET)</u> (Degree or title)	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>Apr. 12-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>	23d. LOCATION (City, town, or county). <u>Wheeling, Missouri</u> (State)
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24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME Missouri</u> ADDRESS <u>Chillicothe,</u>	25. DATE RECD. BY LOCAL REG. <u>4-12-58</u>	26. REGISTRAR'S SIGNATURE <u>Francis B Neill</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Joseph M. Gibson*
Licensed Embalmer No. *4769*
P. O. Address *Chillicothe*

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.