

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044980

STATE FILE NUMBER,

Registration District No. 226 Primary Registration District No. 5801 Registrar's No. 621

FILED JAN 7 1959

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Monroe Co</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Shelbina</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Shelby</u> <u>1020</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Washington Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>G</u> Last <u>Watson</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>22nd</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8th 1885</u>		9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	11. BIRTHPLACE (City and state or country) <u>Shelby Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Thomas Fitzpatrick</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>Isaac Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>725-14-6311</u>	17. INFORMANT Address <u>Rex Gosney Shelbina Mo</u>		
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>Acute Congestive Heart Failure</u> DUE TO (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Hypertension, arteriosclerosis, Heart block, Cholecystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Dec 20 - 22</u> <u>Dec 21, 1958</u> <u>Thanks to day</u>
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Nov 21, 1953</u> to <u>Dec 22, 1958</u> and last saw her alive on <u>Dec 21, 1958</u> Death occurred at <u>5:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Clady Bauer D.O. 2</u>			22b. ADDRESS <u>Shelbina Mo</u>		22c. DATE SIGNED <u>Dec 30, 1958</u>
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/23/58.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crooked Creek Cemetery</u>		23d. LOCATION (City, town, or county) <u>5miles S.W Shelbina Mo</u> (State)
24. FUNERAL DIRECTOR <u>Barkelaw &amp; Davis Shelbina Mo</u>			25. DATE RECD. BY LOCAL REG. <u>12-31-58</u>		26. REGISTRAR'S SIGNATURE <u>Elsie Robertson</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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JAN 19 1959

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 *Tedley A. Barklee*

Licensed Embalmer No. *3835*

P. O. Address *Stellbun, W*

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.