

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 31 1959

59-028537

STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 119

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Length of stay in 1b <u>4 hrs</u>		c. CITY OR TOWN <u>Columbia</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>St. Joseph's Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD #3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>MAY</u> Last <u>WATSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1959</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>May 21/79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Lewis C. Lane</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Langdon</u>			14. NAME OF HUSBAND OR WIFE <u>W. M. Watson</u>		
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 Address <u>Buford Watson RFD #3 Columbia, 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 Myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>± 1 hour</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>							± <u>5 years</u>	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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>8-25-59</u> to <u>8-25-59</u> and last saw her alive on <u>8-25-59</u> Death occurred at <u>8:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>B. M. Stuart, M.D.</u> (Degree or title)				22b. ADDRESS <u>379 Main, Boonville Mo.</u>			22c. DATE SIGNED <u>8/26/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8/27/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>			23d. LOCATION (City, town, or county) <u>Columbia, Mo.</u>		RFD <u>#3</u>	
24. FUNERAL DIRECTOR <u>Memorial Funeral Home Columbia, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>8/26/59</u>		26. REGISTRAR'S SIGNATURE <u>DE Hooper</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 7 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~OR~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Lynman Spencer*

Licensed Embalmer No. 4013

P. O. Address Columbe

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.