URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED 73 SEP 8 1960

60-031798

STATE FILE NUMBER

NDED

Registration District No. 316 Primary Registration District No. — Registrar's No. 341

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington-St.Francois Rural Twp. Length of stay in 1b 16Y;5 M;12das.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. # 4 Inside Limits Yes ☐ No XX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Dent
c. CITY OR TOWN Sligo Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print) First ZORA Middle Last WATSON
4. DATE OF DEATH Month August Day 7 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH 4/16/93
9. AGE (last birthday) 67 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At home
11. BIRTHPLACE (City and state or country) Dent County, Missouri
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Albert Arney
13b. MOTHER'S MAIDEN NAME Mary Cooksey
14. NAME OF HUSBAND OR WIFE Zachary Watson (Decd)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. None
17. INFORMANT Ada Williams Address Steelville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary thrombosis - - - - - - - - - - - - INTERVAL BETWEEN ONSET AND DEATH 2 months.
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)
Mental deficiency - - - - 30 years.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from Feb. 25, 1944 to August 7, 1960 and last saw her alive on 8-7-60
Death occurred at 9:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) [signature]
22b. ADDRESS State Hospital No. 4 Farmington, Missouri
22c. DATE SIGNED 8-8-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8/9/1960
23c. NAME OF CEMETERY OR CREMATORY Cooksey Cemetery
23d. LOCATION (City, town, or county) (State) Dent County, Missouri
24. FUNERAL DIRECTOR Max L. Wright ADDRESS Salem, Mo.
25. DATE RECD. BY LOCAL REG. Sept. 2, 1960
26. REGISTRAR'S SIGNATURE Esther Randolph

(Licensed Embalmer's Statement on Reverse Side)

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 by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Max L. Wa

Licensed Embalmer No. 4170

P. O. Address Salem,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.