

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048503

FILED VS. DEC 21 1960 356

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 106

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Texas</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>WRIGHT</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u> | | Length of stay in 1b <u>1 day</u> | c. CITY OR TOWN <u>Mtn. Grove</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Texas County Memorial</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>106 Bond St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>LOVINA</u> Last <u>WATTS</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u> | | |
| 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"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-9-1875</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 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>None</u> | | 11. BIRTHPLACE (City and state or country) <u>Rolla, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |

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| 13a. FATHER'S NAME <u>JAMES BARKER</u> | | 13b. MOTHER'S MAIDEN NAME <u>Polly Hicks</u> | | 14. NAME OF HUSBAND OR WIFE <u>Robert P. Watts</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 <u>J. R. Graham - Mtn. Grove, Mo</u> | |

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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>BRONCHO PNEUMONIA, BILATERAL</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> |
| DUE TO (b) <u>CROSITIVE ORGANISM UNKNOWN</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) <u>ARTEROSCLEROSIS, GENERALIZED</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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 DEC 9 1960 to DEC 16, 1960 and last saw her him alive on DEC 16, 1960
Death occurred at 11:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>A. J. Dreyer, Jr.</u> (Degree or title) | 22b. ADDRESS <u>Houston, Tex</u> | 22c. DATE SIGNED <u>12-17-60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-17-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u> | 23d. LOCATION (City, town, or county) (State) <u>Newport, Ark.</u> |
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| 24. FUNERAL DIRECTOR <u>Lewell C. Craig</u> ADDRESS <u>Mtn. Grove, Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>Dec. 17-60</u> | 26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Jewell C. Crang

Licensed Embalmer No. 4766

P. O. Address Mtn Grove

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