

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036415

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 298 Primary Registration District No. \_\_\_\_\_ Registrar's No. 3

AMENDED

**FILED NOV 14 1961**

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin</u>		Length of stay in lb <u>Few Minutes</u>	c. CITY OR TOWN <u>Rural Jackson Twp.</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>Office Of Dr. H. Bailey</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Carlow Community</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Fulton Watson</u>			4. DATE OF DEATH Month Day Year <u>November 3 1961</u>
5. SEX <u>Male</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>4-5-1882</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	11. BIRTHPLACE (City and state or country) <u>Harrison Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James Watson</u>	
13b. MOTHER'S MAIDEN NAME <u>(Unknown) Conover</u>		14. NAME OF HUSBAND OR WIFE <u>Leona 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>---</u>	17. INFORMANT Address <u>Everett Watson, Jamesport, 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>Coronary Thrombosis</u> <u>Arterial Sclerosis</u> <u>Coronary trouble past 5 yrs</u> DUE TO (b) <u>Tadon perforated tube past 3 yrs</u> <u>Hypertension, mild cerebral hemorrhage</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>psytia, prostate resection, yagage at times</u> <u>Considerable puss in urine</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Men</u> <u>5 yrs</u> <u>3 yrs age</u>
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 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>June 1950</u> to <u>Nov-3/61</u> and last saw <sup>her</sup> <sub>(him)</sub> alive on <u>Nov-3/61</u> Death occurred at <u>12:15 P.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. Bailey MD</u> (Degree or title)		22b. ADDRESS <u>Gallatin</u>	22c. DATE SIGNED <u>Nov-9/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-5-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Matkins Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrison Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9th Nov. 1961</u>	26. REGISTRAR'S SIGNATURE <u>V. M. Engelhart</u>

**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 L. O. Richesson

Licensed Embalmer No. 3307

P. O. Address Dallatin, Mo

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.