

63 OCT 12 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31907  
Do not use this space.

1. PLACE OF DEATH *Duchaux 3*

(a) County *Duchaux 3* Registration District No. *85*

(b) Township *St Joseph Mo* Primary Registration District No. *1001* Registered No. *953*

(c) City *St Joseph Mo* (d) Street No. *State Hospital #2* St. *Mo*  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred *3-00* yrs. *6* mos. *11* ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Miss M. Watts*

(a) Residence, No. *St Joseph Mo* St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*

4. COLOR OR RACE *W*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single wid.*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *no information*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *? 1887*

7. AGE YEARS *52* MONTHS *?* DAYS *?* If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Box Tender*

9. Industry or business in which work was done, as saw mill, bank, etc. *Box Tender*

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 15 1939*

22. I HEREBY CERTIFY, That I attended deceased from *March 4 1939* to *Sept 15 1939*

I last saw him alive on *Sept 15 1939* Death is said to have occurred on the date stated above, at *4:30 a.m.*

The principal cause of death and related causes of importance were as follows:

*meningo-vascular syphilis with coronary occlusion*

*Chronic paraplegia (from chronic syphilis at the thoracic above) with broncho pneumonia*

Date of onset *undef.*

Other contributory causes of importance: *Chronic paraplegia (from chronic syphilis at the thoracic above) with broncho pneumonia*

Name of operation *none* Date of .....  
What test confirmed diagnosis? *Clinical* Was there an autopsy? *yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify .....

(Signed) *J. T. D. Dell*, M. D.  
(Address) *St Joseph*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Duchaux Mo*

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Mo*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Duchaux Mo*

17. INFORMANT (ADDRESS) *State Hospital Records St Joseph Mo*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Birmingham, Ala.* DATE *Sept. 16 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Fleeman & Son, Inc. 1946 Calhoun St. Joseph, Mo.*

20. FILED *9/18* 19 *39* *A. J. Northcutt* Local Registrar

\*(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*William J. Heenan*

Licensed Embalmer No.

*1448*

P. O. Address

*Joseph, 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 this body is not embalmed, above space should be left blank.**