

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. 176

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Joseph Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution two weeks
(Specify whether
In this community 19 years
years, months or days)

3. (a) PRINT FULL NAME ROY EDWARD WATTS
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 29 1920
(Month) (Day) (Year)

8. AGE: Years 19 Months 7 Days 27
If less than one day hr. _____ min. _____

9. Birthplace St. Charles, Mo. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business _____

MOTHER FATHER {
12. Name EDWARD WATTS
18. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)
14. Maiden name VELEASTON
15. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edward Watts
(b) Address Wilder Springs Mo.

17. (a) BURIAL (b) Date thereof 11-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wilder Springs Mo.

18. (a) Signature of funeral director Morris Muehler
(b) Address Hamburg, Missouri

19. (a) 11/26/39 (b) Clarence H. Wende
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Charles
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 24
year 1939 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from November 8, 1939, to November 24, 1939;
that I last saw him alive on November 24, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death typhoid fever Duration 24 da?

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature Leage Smith (M. D. or other) MD
Address St. Charles, Mo. Date signed Nov 25 1939

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.

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 Morris Murchery
Licensed Embalmer No. 2461
P. O. Address Hamburg, Md.

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.