

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

3978
Do not use this space.

PLACE OF DEATH *Scott*
 (a) County *Scott* Registration District No. *820*
 (b) Township *Salvanea* Primary Registration District No. *4496* Registered No. _____
 (c) City *Oran* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME *320 Lillie M. Watts*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <i>female</i>	4. COLOR OR RACE <i>w</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>widowed</i>		
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>5/5/65</i>				
7. AGE	YEARS <i>7</i>	MONTHS <i>4</i>	DAYS <i>18</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>housekeeper</i>			
	9. Industry or business in which work was done, as saw mill, bank, etc. _____			
	10. Date deceased last worked at this occupation (month and year) _____			
				11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Nashville Tennessee</i>				
FATHER	13. NAME <i>J. C. Hames</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Don't know</i>			
MOTHER	15. MAIDEN NAME <i>Don't know</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Don't know</i>			
17. INFORMANT (ADDRESS) <i>Fred Watts Oran Mo</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Dutchtown</i> DATE <i>1/24</i> 19 <i>40</i>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>T. S. Heister and Co Oran Mo</i>				
20. FILED <i>7/5</i> 19 <i>40</i> <i>J. Stebman</i> <i>735</i> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<i>1/23</i> 19 <i>40</i>
22. I HEREBY CERTIFY, That I attended deceased from _____, 19 <i>39</i> , to <i>1/23</i> , 19 <i>40</i> .	
I last saw him alive on <i>1/22</i> , 19 <i>40</i> . Death is said to have occurred on the date stated above, at <i>2 a.</i> m.	
The principal cause of death and related causes of importance were as follows: <i>chronic Endocarditis</i>	
Other contributory causes of importance: _____	
Name of operation _____	Date of _____
What test confirmed diagnosis? _____	Was there an autopsy? _____
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? <i>no</i> If so, specify _____ (Signed) <i>J. A. Clouse</i> , M. D. (Address) <i>Oran Mo</i>	

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.

RECEIVED

District Health Officer No. 2,

District File Number 240-570

Date Filed 2/9/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.