

Registration District No. 218 1940

Primary Registration District No. 3013

Registrar's No. 16

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Boonville Mo.
(c) Name of hospital or institution: St. Joseph Hospital 1
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 5 1/2

3. (a) PRINT FULL NAME Gerald W. Watson Jr.
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 Feb 24 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 10 hr. _____ min.

9. Birthplace: Boonville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business ✓
12. Name Gerald W. Watson Jr.
13. Birthplace New York
14. Maiden name Mary Virginia Nelson
15. Birthplace Duportail Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gerald Watson Jr.
(b) Address Delbarton Mo
17. (a) Burial (b) Date thereof Feb 25 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Boonville Mo.

18. (a) Signature of funeral director Goodman & Boller
(b) Address Boonville Mo
19. (a) 2-26-40 (b) Boonville
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cooper
(c) City or town Boonville,
(d) Street No. -----
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25
year 1940 hour 1:30 minute A. M.
21. I hereby certify that I attended the deceased from 2-21
2 - 21, 1940, to 2 - 25, 1940;
that I last saw him alive on 2 - 21, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Base injuries Duration 10 hrs
Due to mispropagation of fetal head with
Melvin + attempt for removal
Due to followed by cesarian
section
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Head fail to world.
Of operations _____
Of autopsy _____

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 _____
23. Signature W. Stone (M. D. or other) MD
Address Boonville, Mo Date signed 2-26-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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. 8,
District File Number
3-8-42
Date Filed

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.