

SEP 19 1940

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town West Plains,
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
500 Block, Webster Ave. **2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No
(Specify whether
 In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME SAMUEL B. WATSON **325**

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 June 24, 1850
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>90</u>	<u>0</u>	<u>12</u>	hr. _____ min. _____

9. Birthplace Bloomington, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown **9**

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mo. O.A.A. records.

(b) Address West Plains, Mo.

17. (a) Burial (b) Date thereof 7/7/1940
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation Potter's Field, Howell Township.

18. (a) Signature of funeral director Hal Thompson

(b) Address West Plains, Mo.

19. (a) 7-7-40 (b) Vida W. Simons
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
West Plains, Mo.
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. 500 Block, Webster Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
 year 1940 hour 12: minute 30 P.M.

21. I hereby certify that I attended the deceased from June 24, 1940 to July 26, 1940
 that I last saw him alive on June 26, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Hypertensive myocarditis
 Due to Arteriosclerosis

Due to 121
 Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 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?
44
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature E. C. Bohrer (M. D. or other) md
 Address West Plains, Mo. Date signed 7-10-40

WHILE FILLING IN—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.

I X1951

8401578

840823

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Not Embalmed
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.