

FILLED JUN 16 1941

18320  
State File No. \_\_\_\_\_

Registration District No. 502

Primary Registration District No. 4305

Registrar's No. 17

1. PLACE OF DEATH:  
(a) County LINN  
(b) City or town MARCELINE  
(c) Name of hospital or institution: PUTNAM HOSPITAL  
(d) Length of stay: In hospital or institution 3 days  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME George Henry Watson  
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: JAN 26 1924  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 4 21 hr. — min.

9. Birthplace CALLAO MO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_  
12. Name George Watson  
13. Birthplace Bevier Mo  
14. Maiden name ORPA MAY WALLS  
15. Birthplace CALLAO MO

16. (a) Informant Douglas Leber  
(b) Address Salisbury, Missouri  
17. (a) Amid (b) Date thereof 5-29-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Cemetery CALLAO  
18. (a) Signature of funeral director R. L. Carver  
(b) Address Bevier Mo  
19. (a) 5-28-41 (b) Oliver Barrett  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Macdonald  
(c) City or town CALLAO REF  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 27  
year 1941 hour 11 minute 30 A.M.  
21. I hereby certify that I attended the deceased from May 25  
\_\_\_\_\_, 1941, to May 27, 1941;  
that I last saw him alive on May 27, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Depressed fracture of skull  
Due to Injury auto accident 529  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident auto  
(b) Date of occurrence May 27, 1941  
(c) Where did injury occur? N. B. Linn Missouri  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
4 51 Public highway  
While at work? no (e) Means of injury auto accident  
23. Signature W. B. Putnam (M. D. or other) MD  
Address Marceline Mo Date signed 5/27/41

Duration  
3 da  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

17026  
98

**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 W. Edwards

Licensed Embalmer No. 1961

P. O. Address Brewer 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 502

Primary Registration District No. 4305-

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Marceline  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Geo Henry Watson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race W  
6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 4 21 hr min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Depressed fracture of skull Duration \_\_\_\_\_

Due to Injury auto acc.

Due to Collision with another auto

Other conditions \_\_\_\_\_ (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) acc

(b) Date of occurrence May 24 1941

(c) Where did injury occur? in car (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature G. B. Putnam (M. D. or other) M.D.

Address Marceline \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

