No. 2
9-4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6974

Registration District No. 708 Primary Registration District No. 3020 Registrar's No. 37

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

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stone Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 days. (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry 5
(c) City or town Washburn, Mo. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Arlene Olefia Watson
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) ~~Single, widowed~~, married, ~~divorced~~ Married
6. (b) Name of husband or wife Gaylen Watson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct. (Month) 3 (Day) 1910 (Year)

8. AGE: Years	Months	Days	If less than one day
31	4	17	hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Everett Roberts
13. Birthplace Don't Know (City, town, or county) (State or foreign country)
14. Maiden name Ollie Knapp
15. Birthplace Don't Know (City, town, or county) (State or foreign country)
16. (a) Informant Gaylen Watson
(b) Address Washburn, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-42 (Month) (Day) (Year)
(c) Place: burial or cremation Washburn Prairie
18. (a) Signature of funeral director Keon Funeral Home
(b) Address Cassville, Mo.
19. (a) Feb 23, 1942 (Date received local registrar) (b) Elizabeth Coughlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20th year 1942 hour 5 minute 28 P.M.
21. I hereby certify that I attended the deceased from Jan 22, 1942 to Feb 20, 1942 that I last saw he alive on Feb 20 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	6 mo.
Due to Secondary Anemia	6 mo.
Due to Pelvic Peritonitis	
Other conditions (Include pregnancy within 3 months of death) Endometritis	
Major findings: Fibroid tumors	

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? (Specify type of place)
While at work? — (e) Means of injury —
23. Signature Albert B. Wheeler (M.D. or other) D.O.
Address Carthage, Mo. Date signed Feb 23-42

(Licensed Embalmer's Statement on Reverse Side)

42-2-133

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 Howard L Haman

Licensed Embalmer No. 4122

P. O. Address Cassville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6974

Registration District No. 408 Primary Registration District No. 3020 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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)

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

3. (a) PRINT FULL NAME Arlene O. Watson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 3 (Day) 1910 (Year)

8. AGE: Years 31 Months 4 Days 7 If less than one day or min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1942 hour minute M.

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

Immediate cause of death Duration

Fibroid Tumors

Due to Was puerperal

Due to Suffered from shock

Other conditions
(Include pregnancy within 3 months of death)
Since surgery in

Major findings:
Of operations Gen. Hospital. K.C. Mo

Of autopsy Tumors partially removed. Operation abandoned before removal of uterus because of shock

PHYSICIAN
I indicate 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)

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

While at work? (c) Means of injury

23. Signature A. P. Wheeler (M.D. or other)

Address Date signed