No. 2
7-1-41
-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 14 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

20757

State File No. 340

Registrar's No. 604

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community 8 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan 11

(c) City or town Saint Joseph, (If outside city or town limits, write "RURAL") 7

(d) Street No. 1511 Jules Street, (If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Blanche Watson,

3. (b) If veteran, name war None,

3. (c) Social Security No. 500-07-2047

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Alfred H. Watson,

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

7. Birth date of deceased January 25th. 1890 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	4	26	hr. min.

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

10. Usual occupation Linnen Checker,

11. Industry or business Apartment House

FATHER
12. Name Thomas Stephens,
13. Birthplace Andrew County, Missouri, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Ann White,
15. Birthplace Clinton County, Missouri, (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Theodore Taylor

(b) Address 1222 North 6th. Street,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/42 (Month) (Day) (Year)

(c) Place: burial or cremation Stewartsville, Mo.

18. (a) Signature of funeral director Weston, B. Gale & Bowman Funeral Home

(b) Address 319 So. 10th. Street,

19. (a) 6-23-42 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st. year 1942 hour 10:00 minute 45 p.M.

21. I hereby certify that I attended the deceased from June 21, 1942 to June 21, 1942 that I last saw her alive on June 21, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Hernia of omentum — Duration 2 days

~~Due to~~ Fixed omentum with hernia — much of the ileum strangulated.

~~Due to~~ About two-thirds of ileum gangrenous —

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations as above

Of autopsy as above

Had been in hospital 2 days

122 f 2

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 E. Grant (M. D. or other) MD

Address St. Joseph, Mo Date signed 6/22/42

1255

(Licensed Embalmer's Statement on Reverse Side)

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 6-21-42

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

working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. 10 St. Joseph M

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.

V. S. No. 2B
10M—8-21-41
[illegible] I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20 757

Registration District No. 85 Primary Registration District No. 1001 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 years, months or days)
In this community

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 Mary B. Walton
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 25 (Day) 1890 (Year)
8. AGE: Years 52 Months 4 Days 26 (If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (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) 6-22-42 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19, 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY