

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Forest City
(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 1 day
In this community 33 years
years, months or days) (Specify whether)

3. (a) PRINT FULL NAME GEORGE WATSON
3. (b) If veteran, name war None 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bernie Watson 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased March 25 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 9 hr. min.

9. Birthplace Oregon Mo. 1
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business
12. Name Samuel Watson
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Carter
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Claire Watson
(b) Address Forest City Mo.
17. (a) Burial (b) Date thereof 4 5 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oregon Mo.
18. (a) Signature of funeral director James H. Pettyjohn
(b) Address Oregon Mo.
19. (a) 4-5-43 (b) W. H. Hering
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Holt 44
(c) City or town Forest City 0
(If outside city or town, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 3
year 1943 hour 8 minute 40 A.M.
21. I hereby certify that I attended the deceased from 4-2 1943 to 4-3 1943
that I last saw him well alive on 4-3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Asphyxia Duration 12 hrs
Due to arteriosclerosis general
Due to _____
Other conditions Cerebral Thrombosis
(Include pregnancy within 3 months of death)
Major findings: heart disease
Of operations _____
Of autopsy 930

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) (a) Means of injury _____
23. Signature W. H. Hering (M. D. or other) _____
Address Forest City Mo. Date signed 3-4-43

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

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{will be} was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

James H. Pettijohn

Licensed Embalmer No. *3492*

P. O. Address *Oregon, 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.