

S. No. 2  
4-9-41  
7-5-17-39  
X294

Dr. Vinyard 14363

State File No. ....

Registrar's No. 297

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED APR 28 1949 128  
Registration District No. ....

Primary Registration District No. 2000

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

39  
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1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield

(c) Name of hospital or institution: St. John Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days  
In this community 15 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas <sup>30</sup>

(c) City or town Red Top <sup>0</sup>  
(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 Austin W. Watson

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month April day 12 year 1943 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from 3-29 <sup>18</sup> to 4-12 <sup>1943</sup>  
that I last saw him alive on 4-11 <sup>1943</sup>  
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Nannie L. Watson

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

7. Birth date of deceased Feb. 9 1872  
(Month) (Day) (Year)

Immediate cause of death Carcinoma Prostate ?

Duration ?

Due to ..... 51

Due to .....

Other conditions (include pregnancy within 3 months of death) .....

8. AGE: Years Months Days If less than one day

71 2 3 hr. min.

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

10. Usual occupation Farmer

Major findings: Carcinoma Prostate

Of operations .....

Of autopsy .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business .....

12. Name John Wesley Watson

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

14. Maiden name Mollie Clover

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

16. (a) Informant Wesley Watson

(b) Address Wellington, Kansas

17. (a) Burial (b) Date thereof 4-17-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director H.W. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 4-16-43 (b) W. E. Handley  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury 0

23. Signature Dr. Vinyard (M. D. or other)

Address Springfield Mo Date signed 4-14-49

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see ad

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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 was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Walter E. Hamilton  
Licensed Embalmer No. 3808  
P. O. Address Springfield 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.

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