

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED MAY 17 1946**  
 STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
 Registrar's No. 520

Registration District No. 42 Primary Registration District No. 1000

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:  
1102 So. 22nd. St.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 25 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1102 So. 22nd. St.  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Oliver Siegel Watson  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 1  
 year 1946 hour 10 minute 55 P.M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Mathilda  
 6. (c) Age of husband or wife if alive 22 years  
 7. Birth date of deceased July (Month) 28 (Day) 1863 (Year)

21. I hereby certify that I attended the deceased from April 1946, to May 1 1946  
 that I last saw him alive on April 29 1946  
 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 9 Days 9  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage  
 Duration \_\_\_\_\_

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

Due to arterial sclerosis  
 Due to \_\_\_\_\_

10. Usual occupation Retired Horse Shoer

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business Own  
 12. Name J. O. Watson  
 13. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah A. Mahan  
 15. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations 83"  
 Of autopsy ✓  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Ray O. Watson  
 (b) Address 1102 So. 22nd. St.

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof May 4, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Memorial Park Cem.

While at work? ✓ (Specify type of place) \_\_\_\_\_  
 (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Arthur W. Hildebrand  
 (b) Address 1802 Union St. St. Joseph, Mo.  
 19. (a) May 3, 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

23. Signature Collis Kennedy (M. D. or other) \_\_\_\_\_  
 Address Knappa, La. Date signed May 2, 1946

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

14734

**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 *Herman W. S. Schneider*

Licensed Embalmer No. *2728*

P. O. Address *St. Joseph 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.**