

FILED JAN 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 44218

Registration District No. 73

Primary Registration District No. 5336

Registrar's No. 109

1. PLACE OF DEATH:

(a) County DADE  
(b) City or town RURAL - CENTER TOWNSHIP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4 MILES WEST OF GREENFIELD  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NONE (Specify whether  
In this community 72 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DADE 29  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 MILES WEST OF GREENFIELD  
(If rural, give location):  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 19  
year 1947 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from  
8-20-1947 to 12-16-1947  
that I last saw him alive on 12-16-1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Duration  
of the sigmoid flexor

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 W.D. Combs (M. D. or other).....  
Address Lakewood Mo Date signed 12-22-47

3. (a) PRINT FULL NAME OTTO WATSON

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MILLIE WATSON 6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased MARCH 25 1875  
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 24 If less than one day  
hr. min.

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

10. Usual occupation FARMER

11. Industry or business.....

12. Name LINDSES WATSON

13. Birthplace No RECORD 9  
(City, town, or county) (State or foreign country)

14. Maiden name SARAH HAMPTON

15. Birthplace No RECORD 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Loda Watson

(b) Address Greenfield, Mo.

17. (a) BURIAL (b) Date thereof 12-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NETZEL CEMETERY

18. (c) Signature of funeral director Sam E. Remney Jr.  
(b) Address Greenfield, Mo.

19. (a) 12-21-47 (b) Geo L. New  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 67

District File Number 148-82

Date Filed JAN 14 1948

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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 *Sam E. Sweeney Jr*  
Licensed Embalmer No. 4099  
P. O. Address *Greenfield, 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.