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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 10 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 71

Registration District No. _____

Primary Registration District No. 3000

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
804 E. Line St.
(If not in hospital or institution, write street number or location)

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

In this community Life
years, months or days)

3. (a) PRINT FULL NAME JOHN LARKIN WATSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male ()

5. Color or race White

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

6. (b) Name of husband or wife Lucy Jane Watson

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

7. Birth date of deceased January 14 1856
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
92	1	11	hr. min.

9. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name William Watson

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

14. Maiden name Elizabeth Jane Dixon

15. Birthplace DK Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Otto

(b) Address 804 E. Line St. Kirksville, Mo.

17. (a) Burial (b) Date thereof 2-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Park Cemetery

18. (a) Signature of funeral director Davis Funeral Home

(b) Address Kirksville, Mo.

19. (a) 3-4-48 (b) W. H. Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirksville
(If outside city or town limits, write "RURAL")

(d) Street No. 804 E. Line St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26
year 1948 hour 6:00 minute _____ P.M.

21. I hereby certify that I attended the deceased from February, 16
1948, to February, 26, 1948.
That I last saw him alive on February, 26, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 10 da.

Due to Glomerulonephritis Many years

Due to *****

Other conditions *****
(Include pregnancy within 3 months of death)

Major findings:
Of operations N. P. N. 90mg.
Alb. III Clumps of W.B.E.
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?

While at work ***** (Specify type of place) (e) Means of injury *****

23. Signature Dr. H. T. R. [Signature] (M. D. or other) M. D.
Address Kirksville, Mo. Date signed 3/3/48

MAR 12 1948

RECEIVED

District Health Officer No. 3:48

District File Number

Date Filed MAR 8 1948

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

Clarence M. Billo

Licensed Embalmer No.

9375

P. O. Address

Kissimmee, Fla.

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.