

FILED OCT 6 1948

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 279

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: 615 N Franklin
(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

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

3. (a) PRINT FULL NAME Albert Francis Watts
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 25 year 1948 hour 10 minute 05 A.M.
21. I hereby certify that I attended the deceased from Sept 25th 1948 to Sept 25 1948 that I last saw him alive on Sept 25 1948 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Leona Lee Watts
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased: 12 23 1867
(Month) (Day) (Year)

Immediate cause of death
Due to Cancer of upper mediastinum
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
80 9 2 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____
12. Name Francis Marion Watts
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Rachel A Harris
15. Birthplace Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Quorn H Watts
(b) Address 615 N Franklin St

17. (a) Burial (b) Date thereof Sept 27
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Cem

18. (a) Signature of funeral director: Glenon E Hunt's Son
(b) Address Green City, Mo

19. (a) 9-29-48 (b) Kate Lambert
(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 _____
23. Signature J. T. Rhoads (M.D. or other) _____
Address Kirksville, Mo Date signed 9-27-48

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

MOTHER FATHER

REC-20

District Health Officer No. 10

District File Number 10-48-1731

~~OCT 5 - 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.....

Karl R. Kent

....., Registered Apprentice No. 242

working under my personal supervision.

Signed

Glenn E. Kent

Licensed Embalmer No. 1769

P. O. Address

Green City, 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.