

FILED MAR 24 1949

STANDARD CERTIFICATE OF DEATH

State File No. 7739

No. 300
10.48

24

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

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>33</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>CLAY</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>2 Yrs.</u>		a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSP.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>		d. STREET ADDRESS (If rural, give location) <u>116 SARATOGA</u>			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>ARCHIE</u>	b. (Middle) <u>E.</u>	c. (Last) <u>WATSON</u>	(Month) <u>Mar.</u>	(Day) <u>8,</u>	(Year) <u>1949</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 21, 1863</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u>	IF UNDER 24 Hrs. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>		11. BIRTHPLACE (State or foreign country) <u>ALLIANCE, OHIO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>JAMES WATSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY SLAVEN</u>		14. NAME OF HUSBAND OR WIFE <u>CAPITOLA BOBAGH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records - Ex. Springs, Mo.</u> ADDRESS <u>Ex. Springs, Mo.</u>				
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia - chronic nephritis</u>					<u>4 days</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					
		DUE TO (c) <u>Arteriosclerosis</u>					<u>10 years</u>
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5410</u>					
19a. DATE OF OPERATION <u>3/3/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Nephrotic obstruction - Nephrotic divisional ulcer</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/30, 1948</u> , to <u>3-8</u> , 1949, that I last saw the deceased alive on <u>3/9</u> , 1949, and that death occurred at <u>3:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. S. Johnson</u> (Degree or title) <u>Dr.</u>				23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>3/9/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>3/9/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shawnee, Kansas</u>		24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. <u>3/9/49</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Crickard</u> ADDRESS <u>Ex. Springs, Mo.</u>			

RECEIVED

District Health Officer No. 8,

District File Number 3

Date Filed 3-22-49

APR 2 1949
DISTRICT HEALTH OFFICER

1949
APR 1

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

E. J. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs, 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.