

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Fitch
State File No. 15594

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 2000 Registrar's No. 478

39
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield, Mo.	
c. LENGTH OF STAY (In this place) 40 Yrs.		d. STREET ADDRESS (If rural, give location) 926 E. Central	
d. FULL NAME OF HOSPITAL OR INSTITUTION 926 E. Central			

3. NAME OF DECEASED (Type or Print) a. (First) Robert	b. (Middle) A.	c. (Last) Watson	4. DATE OF DEATH (Month) (Day) (Year) May 28, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH April 10 1878	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Supv.	10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.	11. BIRTHPLACE (State or foreign country) Butler Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Alexander Watson	13b. MOTHER'S MAIDEN NAME Mary Coffrin	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Mrs. C.O. Baker, Aburn, Ind.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respirator		
	ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Mar 1949, to May 28, 1949, that I last saw the deceased alive on May 25, 1949, and that death occurred at 11 a. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Thos Fitch</i>	(Degree or title)	23b. ADDRESS <i>W.D. 1 Springfield, Mo</i>	23c. DATE SIGNED <i>5-31-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/31/49	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 5/31/49	REGISTRAR'S SIGNATURE <i>W.S. Handley W.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Lohmeyer</i>	ADDRESS Springfield, Mo.
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37610-2799

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

Walter E. Hamelin

Licensed Embalmer No.

3808

P. O. Address

Springfield 194

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.