

FILED JUN 16 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19682

BIRTH NO.		REG. DIST. NO. 70	PRIMARY REG. DIST. NO. 4124	Registrar's No. 26
1. PLACE OF DEATH a. COUNTY Clark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Clark		
d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kahaha		c. LENGTH OF STAY (Month place) life		
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kahaha 02.30		
d. STREET ADDRESS (If rural, give location)		0		
3. NAME OF DECEASED (Type or Print)		a. (First) Melissa	b. (Middle) Jane	c. (Last) Watson
4. DATE OF DEATH (Month) (Day) (Year)		May 30 1951		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 7-1868	9. AGE (In years last birthday) 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Nichols		
13b. MOTHER'S MAIDEN NAME Mary Davenport Mortan		14. NAME OF HUSBAND OR WIFE H. Watson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Clayton Watson
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (b) Senility		
DUE TO (c)				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 5/22 1951 to 5/30 1951, that I last saw the deceased alive on 5/30 1951, and that death occurred at 8:15 A.M., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) A. B. Bridges M.D.		23b. ADDRESS Kahaha Mo		23c. DATE SIGNED 7-9-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 3-1951		24c. NAME OF CEMETERY OR CREMATORY Kahaha Ce
24d. LOCATION (City, town, or county) (State) Kahaha Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
DATE REC'D BY LOCAL REG 6/9-51		REGISTRAR'S SIGNATURE A. B. Bridges 61		Funeral Home, Kahaha

(Licensed Embalmer's Statement on Reverse Side)

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

Date Received: JUN 1 1 1951  
DISTRICT HEALTH OFFICE #2  
District File Number 6-57-1088  
Date Filed: JUN 1 4 1951

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Otis L. Tutting*

Signed.....

Student Embalmer

Licensed Embalmer No. *2963*

P. O. Address *Curry*

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.