

FILED JAN

8 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42574

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 293 PRIMARY REG. DIST. NO. 4436 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Ralls</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ralls</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>New London</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>New London</u> <u>0870</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JAMES</u>	b. (Middle) <u>URTON</u>	c. (Last) <u>WATSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 5-1951</u>
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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>Aug 12-1950</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>FONTAIN WATSON</u>	13b. MOTHER'S MAIDEN NAME <u>SALLIE PRIEST</u>	14. NAME OF HUSBAND OR WIFE <u>RUTH WATSON</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ruth Watson</u> ADDRESS <u>New London Mo</u>
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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 <u>2 days</u>  <u>10 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetic Coma</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Osteo-Arthritis</u> 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) <u>260 X</u>
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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 Nov 1, 1951 to Dec 5, 1951, that I last saw the deceased alive on Dec 4, 1951, and that death occurred at 7:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. T. Waters</u> (Degree or title) <u>D. M. D.</u>	23b. ADDRESS <u>New London Mo</u>	23c. DATE SIGNED <u>12-8-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 8, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>New London Mo</u>
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DATE REC'D BY LOCAL REG. <u>12 8 51</u>	REGISTRAR'S SIGNATURE <u>W. T. Waters</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jules W. Son</u> ADDRESS <u>Frankford Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

870  
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NOV 8 1956

Date Received: JAN 3  
DISTRICT HEALTH OFFICE  
District File Number /-5  
Date Filed: JAN 5

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.....

*Jane Fields Megowan*

Licensed Embalmer No. *4073*

P. O. Address *Frankford Pa.*

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.