

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43832
State File No.

FILED JAN 9 1952

BIRTH NO. --- REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 3076 Registrar's No. 210

082

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

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada	
c. LENGTH OF STAY (in this place) 68 years		d. STREET ADDRESS (If rural, give location) 401 East Atlantic	
d. FULL NAME OF HOSPITAL OR INSTITUTION 401 East Atlantic			

3. NAME OF DECEASED (Type or Print) Mary Ellen Watts	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH December 28, 1951
				(Month) (Day) (Year)

5. SEX Fm	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 21, 1881	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR	IF UNDER 1 MONTH
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Alpha Stump	13b. MOTHER'S MAIDEN NAME Lottie Colclessor	14. NAME OF HUSBAND OR WIFE Elmer Ray Watts
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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. None	17. INFORMANT'S SIGNATURE OR NAME Harvey F. Stump	ADDRESS Nevada, Missouri
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Major coronary occlusion		0
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Minor coronary occlusion DUE TO (c) Coronary artery disease		3 mo.
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 **Nov. 1951**, to **Dec. 28, 1951**, that I last saw the deceased alive on **Dec. 26, 1951**, and that death occurred at **2:45 P** m., from the causes and on the date stated above.

23a. SIGNATURE CR Angus M. W. (Degree or title)	23b. ADDRESS Nevada, Mo	23c. DATE SIGNED 12-31-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 31, 1951	24c. NAME OF CEMETERY OR CREMATORY Newton Burial Park	24d. LOCATION (City, town, or county) (State) Nevada Missouri
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DATE REC'D BY LOCAL REG. 12-31-1951	REGISTRAR'S SIGNATURE Anna E. Ferry	25. FUNERAL DIRECTOR'S SIGNATURE Ferry Funeral Home	ADDRESS Nevada, Mo.
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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 *L. B. Ferry*.....

Licensed Embalmer No. 11260

P. O. Address Nebraska, 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.