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

FILED NOV 17 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38368

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1011

1. PLACE OF DEATH
a. COUNTY: Greene County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield Mo
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Christian Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bruner. Mo
d. STREET ADDRESS (If rural, give location): Bruner Mo

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3. NAME OF DECEASED (Type or Print): a. (First) J. R. b. (Middle) R c. (Last) Watts
4. DATE OF DEATH: (Month) Nov (Day) 12 (Year) 1952
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov 10. 1860
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and State or Foreign Country): Mo
12. CITIZEN OF WHAT COUNTRY? US A
13a. FATHER'S NAME: Wm Riley Watts
13b. MOTHER'S MAIDEN NAME: Not Known
14. NAME OF HUSBAND OR WIFE: ——
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Leroy watts. Bruner Mo

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hypostatic Pneumonia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
4221
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9, 1952, *to* 11-12, 1952; *that I last saw the deceased alive on* 11-11, 1952; *and that death occurred at* 5:55 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: John W. Williams Jr. (Degree or title)
23b. ADDRESS: Springfield Mo
23c. DATE SIGNED: 11-13-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 15. 1052
24c. NAME OF CEMETERY OR CREMATORY: Bethel.
24d. LOCATION (City, town, or county) (State): Taney Co Mo

DATE REC'D BY LOCAL REG.: 11-14-52
REGISTRAR'S SIGNATURE: Deputy Registrar Erich Williamson
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: T. B. Chaffin Ozark, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.