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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42864

BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 3044 Registrar's No. 52

1. PLACE OF DEATH
a. COUNTY: Miller
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eldon
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 525-E-8th St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Miller
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eldon 1661
d. STREET ADDRESS (If rural, give location): 525-E 8th St

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Boon
c. (Last): Watts

4. DATE OF DEATH (Month) (Day) (Year): Dec-22-1952

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 24 July 1867
9. AGE (In years last birthday): 85
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: Gen-Farming
11. BIRTHPLACE (State or foreign country): Cole-Co-Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John-K-Watts
13b. MOTHER'S MAIDEN NAME: Syntha-Payne
14. NAME OF HUSBAND OR WIFE: Alice-Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Alice-Watts
ADDRESS: Eldon Mo

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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart 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) arteriosclerosis & hypertension
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: None
19b. MAJOR FINDINGS OF OPERATION: None
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20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): None

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: None

22. *I hereby certify that I attended the deceased from* _____, 19 48, *to* Dec 22, 19 52, *that I last saw the deceased alive on* Dec 20, 19 52, *and that death occurred at* 2:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. O. Sherton M.D. (Degree or title)
23b. ADDRESS: Eldon Mo
23c. DATE SIGNED: 23 Dec 52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 24 Dec 52
24c. NAME OF CEMETERY OR CREMATORY: Dooley
24d. LOCATION (City, town, or county) (State): Miller-Co-Mo

DATE REC'D BY LOCAL REG.: Dec. 23, 52
REGISTRAR'S SIGNATURE: Alvernetta Walt 192-0
25. FUNERAL DIRECTOR'S SIGNATURE: Kelly M Rayes
ADDRESS: Eldon Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 Keith M Kaye

Licensed Embalmer No. 3998

P. O. Address Eldon 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.