

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 263883

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 951

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	
c. LENGTH OF STAY (If in hospital or institution) 33 yrs		d. STREET ADDRESS (If rural, give location) 511 Highland East Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE		b. (Middle) VIRGIL		c. (Last) WATSON		4. DATE OF DEATH (Month) (Day) (Year) Aug 27 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 23, 1887	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Evona Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Pascchal Watson		13b. MOTHER'S MAIDEN NAME Elizabeth Duckworth		14. NAME OF HUSBAND OR WIFE Susan Watson	
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. 491-10-5210		17. INFORMANT'S SIGNATURE OR NAME Mrs. Susan Watson	
				ADDRESS St. Joseph, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia left lung		ANTECEDENT CAUSES		48 hrs.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of head of pancreas invading common bile duct with severe obstructive jaundice		Symptoms 3 weeks	
		DUE TO (c) Cardiac dilatation, plus auricular fibrillation		not known	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		as in diagnosis - confirmed by autopsy - cholecyst-gastrostomy, functioned satisfactorily			

19a. DATE OF OPERATION 8-23-54		19b. MAJOR FINDINGS OF OPERATION as in diagnosis - confirmed by autopsy - cholecyst-gastrostomy, functioned satisfactorily		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 157X	
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?	

22. I hereby certify that I attended the deceased from **8-11, 1954**, to **8-27, 1954**, that I last saw the deceased alive on **8-27, 1954**, and that death occurred at **7:20A** m., from the causes and on the date stated above.

23a. SIGNATURE Thompson P. Peter		(Degree or title) M.D.		23b. ADDRESS 731 Faron St. St. Joseph 54 Mo.		23c. DATE SIGNED 8-28-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 30, 1954		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph Missouri	

DATE REC'D BY LOCAL REG. Sep 2, 1954		REGISTRAR'S SIGNATURE Esther M. Allison		FUNERAL DIRECTOR'S SIGNATURE Stoney Funeral Home St. Joseph, Mo		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10561 7 - 4011

SEP 14 1957

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 Charles E. Bennett

Signed.....
Student Embalmer

Licensed Embalmer No. 4625

P. O. Address St Joseph 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.