

FILED MAY 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15940

State File No. 5158

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 5158

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Linn	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brookfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Boston	
c. LENGTH OF STAY (In this place) 2 mos		d. STREET ADDRESS (If rural, give location) RFD	
d. FULL NAME OF HOSPITAL OR INSTITUTION Cramer Convalescent Home			

3. NAME OF DECEASED (Type or Print) LAWRENCE M. WATSON			4. DATE OF DEATH May 13, 1955		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 11, 1887	
9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Linn Co. Missouri	
				12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Drury Watson		13b. MOTHER'S MAIDEN NAME Mary F. Allegor		14. NAME OF HUSBAND OR WIFE Grace Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME E. B. Watson, Brookfield, Mo. ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation (congestive failure)		DUE TO (b) Myocarditis			120 days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			7 mos.
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"/>	
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)		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 **Feb. 22, 1955**, to **May 13, 1955**, that I last saw the deceased alive on **May 13, 1955**, and that death occurred at **10:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE John W. White, D. O. (Degree or title)		23b. ADDRESS Brookfield, Mo.		23c. DATE SIGNED 5/14/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 15, 1955		24c. NAME OF CEMETERY OR CREMATORY Price Cemetery	
				24d. LOCATION (City, town, or county) (State) Winigan, Mo.	

DATE REC'D BY LOCAL REG. 5-14-55		REGISTRAR'S SIGNATURE [Signature] 167-0		25. FUNERAL DIRECTOR'S SIGNATURE Wright Funeral Home, Brookfield, Mo. ADDRESS	
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(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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.