

Health,  
Welfare  
Public  
Service

300  
1-56

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 10 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 37729

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1094-E

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Ash Grove</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>			Length of stay in lb <b>4 weeks</b>			d. STREET ADDRESS <b>R. R. 1</b> (If outside, give location)		
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>LILLIAN</b> Last <b>WATSON</b>				4. DATE OF DEATH <b>Nov 29, 1956</b> Month <b>Nov</b> Day <b>29</b> Year <b>1956</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1898</b>		9. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>3</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Ash Grove, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Jowle Mc Cormick</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Cyril Watson, Ash Grove, Mo.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis + ileitis</b> DUE TO (b) <b>Recurring Ulcerative Colitis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Uremia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo's</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>June 1956</b> , to <b>Nov 29, 1956</b> and last saw her/him alive on <b>Nov 29, 1956</b> Death occurred at <b>11:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>T. D. Duncan M.D.</b>				22b. ADDRESS <b>Springfield Mo</b>		22c. DATE SIGNED <b>12/3/56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Dec 1, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ash Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ash Grove, Mo.</b>			
24. FUNERAL DIRECTOR <b>Brim - Daniel - Ash Grove - Mo 12-6-56</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>12-6-56</b>		26. REGISTRAR'S SIGNATURE <b>Walter Williamson</b>			

(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.....  
Signature of Student Embalmer

Signed *Gayle L. Samuel*.....  
47

Licensed Embalmer No.....

P. O. Address.....  
*Del Gr...*  
*Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.