

FILED MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <u>Bosne</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pennsolt</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Caruthersville</u> <u>0782</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. V. Mo. Med. Center</u>		Length of stay in lb <u>4 days</u>	d. STREET ADDRESS (If outside, give location) <u>301 E. 13th</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILL</u> Middle <u></u> Last <u>WATSON</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 1 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 14 - 1894</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Wicksburg, Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Joe Watson</u>			14. MOTHER'S MAIDEN NAME <u>Lizzie Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>492-013936</u>		17. INFORMANT <u>Hospital Records</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u></u> 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 (a) <u>Carcinoma of the head of pancreas</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>unknown</u>
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.) <u></u>			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>					
20d. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>2-22-57</u> to <u>2-26-57</u> and last saw her alive on <u>2-26-57</u> Death occurred at <u>7:25 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>B. A. Masonville II, M.D.</u>			22b. ADDRESS <u>University Hospital</u>		22c. DATE SIGNED <u>2-26-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Feb. 27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Caruthersville</u>		23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker</u> ADDRESS <u>Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 27 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 7-56

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Edward H. Truog*

Licensed Embalmer No. *119*

P. O. Address *Columbia*

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.