

Health,
Welfare
Public
Service

300
1-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 30 1957

25204

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 121

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Competition Mo.</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>Wallace Hosp.</u>		Length of stay in 1b <u>12 days</u>	d. STREET ADDRESS <u>R.R. # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sherman</u> Middle <u>Sylvester</u> Last <u>Watterson</u>			4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1882</u>	9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Month <u> </u> Day <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Month <u> </u> Day <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Lynn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John D. Watterson</u>			14. MOTHER'S MAIDEN NAME <u>Marjorie Massey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. May Clark</u> Address <u>Competition Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Surgical repair Ventral hernia</u>					<u>7 days.</u>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>5603</u>		
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 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>7/8/57</u> to <u>7/19/57</u> and last saw her/him alive on <u>7/18/57</u> . Death occurred at <u>6: A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. H. Johnson</u> (Degree or title) <u>MD</u>			22b. ADDRESS <u>Lebanon Mo</u>		22c. DATE SIGNED <u>7-21-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/21/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Porter Chapel Cemetery near Competition Mo.</u>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>Hoeman Lebanon Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>July 21-1957</u>	26. REGISTRAR'S SIGNATURE <u>Hella H. Hays</u>

Received 7-29-57
Laclede County Health Unit
File No. 121
Date Filed 7-29-57

STATEMENT BY LICENSED EMBALMER

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

Student,
Signature of Student Embalmer

Signed Dorsey M. Hoi

Licensed Embalmer No. 42

P. O. Address Leban

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.