

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 19 1957

439998
STATE FILE NUMBER

Registration District No. 113 Primary Registration District No. 5430 Registrar's No. 647

| | | | | | | | |
|---|-------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>FRANKLIN</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Central</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>St. Clair, Mo R#2</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u> | | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>R#2</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES MONROE WATTS</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC. 8 1957</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>DEC. 16, 1886</u> | | 9. AGE (In years last birthday) <u>71</u> | IF UNDER 1 YEAR Months Days Hours Min. <u>11 21</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 | | 11. BIRTHPLACE (City and state or country) <u>TEXAS COUNTY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>WILLIAM WATTS</u> | | | 13b. MOTHER'S MAIDEN NAME <u>FLORANCE A. RITCHEY</u> | | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Melvina Herron St. Clair Mo</u> 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) <u>Broncho Pneumonia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Asian Influenza</u> | | | | | | 2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Bronchitis</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT - SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>480X</u> | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 21. I attended the deceased from <u>11-13-57</u> to <u>12-8-57</u> and last saw him alive on <u>Dec-7-57</u> Death occurred at <u>7 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Dr. W. E. Mitchell</u> (Degree or title) | | | | 22b. ADDRESS <u>St. Clair Mo</u> | | 22c. DATE SIGNED <u>12-9-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>DEC. 11, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Union Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Sheldon W. Kitchell, St. Clair, Mo</u> ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. <u>9-Dec-1957</u> | | 26. REGISTRAR'S SIGNATURE <u>H. Lloyd Williams</u> | |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Sherrill W. Kitchell*

Licensed Embalmer No. *3873*

P. O. Address *St. Clair, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.