

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040642

STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 179

Primary Registration District No. 5667

Registrar's No. 187

S. 300  
1-57

|  |  |  |  |   |   |  |   |   |  |   |       |                                |  |
|--|--|--|--|---|---|--|---|---|--|---|-------|--------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>LINCOLN</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>LINCOLN</b>                  |   |  |   |   |  |   |       |                                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>BEDFORD TOWNSHIP</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | c. CITY OR TOWN <b>WINFIELD</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |  |   |       |                                |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>L.C. MEM. HOSP.</b>   |  |  | Length of stay in lb <b>1 DAY</b>  |   | d. STREET ADDRESS (If outside, give location) <b>0570</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |   |       |                                |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>JEANS</b> Last <b>WATTS</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>10,</b> Year <b>1958</b>   |   |  |   |   |  |   |       |                                |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>6-26-75</b>   |   | 9. AGE (In years last birthday) <b>83</b>                           |  | IF UNDER 1 YEAR<br>Months Days Hours Min.         |       | IF UNDER 24 HRS.<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>HAMBURG, ILL.</b>                   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   |       |                                |  |
| 13a. FATHER'S NAME<br><b>ELISHA LAIRD</b>  |  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>MARY TALBERT</b>  |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>GORDON T. WATTS</b>               |  |   |       |                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   | 17. INFORMANT Address<br><b>GORDON T. WATTS - WINFIELD</b>                           |   |   |  |   |       |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Medullary Palsy</b><br>DUE TO (b) <b>Ventricular Fibrillation</b><br>DUE TO (c) <b>Cerebral Hemorrhage</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a)<br><b>Atherosclerosis</b> |  |  |  |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</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<br>Hour Month, Day, Year<br>a.m. p.m.  |  |  |  |   |   |  |   |   |  |   |       |                                |  |
| 20d. INJURY OCCURRED WHILE AT <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 <b>Nov 9 '58</b> to <b>Nov 10, '58</b> and last saw her alive on <b>Nov 10 - 1958</b><br>Death occurred at <b>2:45 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |  |  |   |   |  |   |   |  |   |       |                                |  |
| 22a. SIGNATURE (Degree or title)<br><b>Leonard Carfett D.O.</b>  |  |  |  |   |   | 22b. ADDRESS<br><b>Tray, Mo</b>  |   |   | 22c. DATE SIGNED<br><b>11-12-58</b>        |   |       |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |  |  | 23b. DATE<br><b>Nov. 12, 1958</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKWOOD</b>      |  |   | 23d. LOCATION (City, town, or county) (State)<br><b>ALTON, ILL.</b> |  |   |       |                                |  |
| 24. FUNERAL DIRECTOR<br><b>O. C. Ricks</b>   |  |  |  | ADDRESS<br><b>Eisberry, Mo.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>11-12-1958</b>                                    |   | 26. REGISTRAR'S SIGNATURE<br><b>Charlotte Leek</b>                  |  |   |       |                                |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

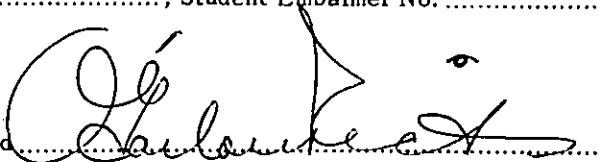
MEDICAL CERTIFICATION

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.

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  .....

Licensed Embalmer No. 4012 .....

P. O. Address Elsberry, 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.