

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008279  
State File No. ....

FILED APR 14 1959

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Missouri</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville, Missouri</u>	c. LENGTH OF STAY (In this place) <u>2 days</u>	c. CITY OR TOWN <u>New Boston</u> <u>c. 590</u>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic Hosp.</u>		STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) <u>Jerry</u>	a. (First)	b. (Middle) <u>Wayne</u>	c. (Last) <u>Watson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>6</u> <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u>	8. DATE OF BIRTH <u>Feb. 1, 1959</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Brookfield</u>	12. COUNTRY OF WHAT CITIZENRY? <u>US</u>	

13a. FATHER'S NAME <u>Walter W. Watson</u>	13b. MOTHER'S MAIDEN NAME <u>Wilma Lucille Pamperl</u>	14. NAME OF HUSBAND OR WIFE
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'S SIGNATURE OR NAME ADDRESS <u>W.W. Watson, New Boston, Mo.</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peripheral Vascular Collapse</u>		<u>2 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Dehydration</u>		<u>15 hours</u>
	DUE TO (c) <u>Inguinal Hernia</u>		<u>15 hours</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Patent Ductus Arteriosus</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>56 cc</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-5-, 19 59, to 4-6, 19 59, that I last saw the deceased alive on 1-6-59, 19     , and that death occurred at 3:50 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Measey</u>	(Disease or title)	23b. ADDRESS <u>Kirksville Mo</u>	23c. DATE SIGNED <u>4-6-59</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/7/59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Boston Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Boston, Mo.</u>

DATE REC'D BY LOCAL REG. <u>4-6-1959</u>	REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Larson Funeral Service, Bucklin, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....  
P. O. Address.....

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.