

Health, Welfare  
Public  
Service

FILED VS JUL 20 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023999

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 213

300  
1-57

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>Scotland</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Granger</u>
c. FULL NAME OF (IF NOT in hospital, give location) of HOSPITAL OR INSTITUTION <u>Community Nursing Home</u>		Length of stay in 1b <u>6 Wks</u>	d. STREET ADDRESS (If outside, give location) <u>0990</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>LDA MAY Belle Watson</u>			4. DATE OF DEATH Month Day Year <u>July 14 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>March 9, 1870</u>		9. AGE (In years last birthday) <u>89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state and country) <u>Scotland Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Wilson Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Anna Craig</u>		14. NAME OF HUSBAND OR WIFE <u>James Watson</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>no</u>	17. INFORMANT Address <u>Mrs Chas Eekle Memphis Mo</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>Medullary Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>weeks</u> <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Encephalomalacia</u>		
	DUE TO (c) <u>Cerebral arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>			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.)		
20c. TIME OF INJURY Hour .Month, Day, Year 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 <u>6-6-59</u> to <u>7-14-59</u> and last saw her alive on <u>7-13-59</u> Death occurred at <u>7:05</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>G. H. Schaefer, D.O.</u>		22b. ADDRESS <u>Kirksville</u>		22c. DATE SIGNED <u>7-14-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BLACK OAK Ceme</u>	23d. LOCATION (City, town, or county) (State) <u>Granger, Mo.</u>
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24. FUNERAL DIRECTOR <u>Judy Barber</u>	ADDRESS <u>Memphis Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-16-1959</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
G. H. SCHAEFER, D.O.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
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 ..... *Fred H. Smith Jr.* .....

Licensed Embalmer No. .... *425-5* .....

P. O. Address ..... *Memphis* .....

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.