

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 9 1959

59-029702

Registration District No. 781 Primary Registration District No. 4293 Registrar's No. 31

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Elsberry Missouri</u>		c. CITY OR TOWN <u>Elsberry Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ladell Nursing Home</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Jess</u> Middle <u>Frank</u> Last <u>Watson</u>	4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1959</u>
---	--

5. SEX <u>Male</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>Nov. 17, 1872</u>	9. AGE (last birthday) <u>86 yr.</u>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
--------------------	-------------------------------	---	---------------------------------------	--------------------------------------	--------------------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Elsberry Mo., Lincoln</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>James A. Watson</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Waggoner</u>	14. NAME OF HUSBAND OR WIFE <u>Elizabeth 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>None</u>	17. INFORMANT Address <u>Ester Mae Schuster, Elsberry 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>Bronchial 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) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Myocarditis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ a.m. _____ p.m. Month, Day, Year _____	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>1-16-58</u> to <u>8-21-59</u> and last saw ^{her} him alive on <u>8-21-59</u> Death occurred at <u>10:30</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>L.H. Callaway D.O.</u>	22b. ADDRESS <u>Elsberry Mo</u>	22c. DATE SIGNED <u>8-25-59</u>
---	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Star Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Elsberry Missouri RFD</u>
--	-----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Ricks Funeral Home, Elsberry Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/27/1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clarence Kintzy</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

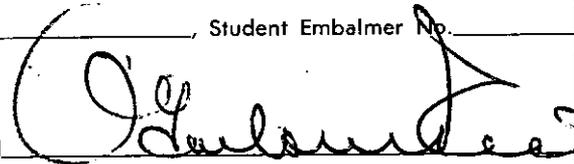
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4017

P. O. Address Elsberry

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.