

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE STANDARD CERTIFICATE OF DEATH

-61-044325

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1221 STATE FILE NUMBER

DR. DUNCAN
FILED DEC 26 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
Length of stay in 1b 21 YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If outside, give location) 829 N. MAIN	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ALLEN L. WATSON			4. DATE OF DEATH Month Day Year DEC. 16 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/15/97	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TICKET AGENT	10b. KIND OF BUSINESS OR INDUSTRY AMERICAN BUS	11. BIRTHPLACE (City and state or country) DE KALB, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME JAMES WATSON	13b. MOTHER'S MAIDEN NAME EMMA BUNDY	14. NAME OF HUSBAND OR WIFE LENORE WATSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. # 1	17. INFORMANT Address LENORE WATSON, SPRINGFIELD, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of larynx		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
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)	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
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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. Month, Day, Year p.m.		

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 SPRINGFIELD, MO.	COUNTY GREENE	STATE
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21. I attended the deceased from Nov 1960 to Dec 16, 1961 and last saw her/him alive on Dec 16, 1961
Death occurred at 5 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. Robert D. Duncan, M.D.	22b. ADDRESS Springfield, Mo	22c. DATE SIGNED 12/18/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/18/61	23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL	23d. LOCATION (City, town, or county) SPRINGFIELD, MO.
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24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 12-21-61	26. REGISTRAR'S SIGNATURE Eddie S. Meeton
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

DEC 29 1961

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 W. H. McCann

Licensed Embalmer No. 2727

P. O. Address Spfld

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.