

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010435

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 219

FILED MAR 25 1963

VS 300
Rev. 4/59

1 0109
2 00472
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4 0
5 2
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7 0
8 1
9 4200
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12 2-0
13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>AUDRAIN</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Length of stay in 1b. <u>3 days</u>	c. CITY OR TOWN <u>MEXICO</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MISSOURI MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>615 ME FARLAND</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BURL ODEN WATSON</u>		4. DATE OF DEATH Month Day Year <u>MARCH 20, 1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1894</u>
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 <u>LANCASTER, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>LA FAYETTE WATSON</u>		13b. MOTHER'S MAIDEN NAME <u>FANNIE BEELER</u>	14. NAME OF HUSBAND OR WIFE <u>Dec.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes May 25, 1918 to June 1919</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>UNIVERSITY OF MISSOURI MEDICAL CENTER</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>Arteriosclerotic Heart Disease with Severe Congestive Heart Failure</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> 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>Pulmonary infarction due to Pulm. Embolus</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			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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		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>3-18-63</u> to <u>3-20-63</u> and last saw ^{her} him alive on <u>3-20-63</u> . Death occurred at <u>6:15</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Typed or title) <u>Michael R. Palmer MD</u>		22b. ADDRESS <u>Univ. of Mo. Med. Center, Columbia</u>	22c. DATE SIGNED <u>3-20-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/23/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Downing, Missouri</u>
24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar 20, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

(Licensed Embalmer's Statement on Reverse Side)

APR 3 1963

APR 15 1963

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 *Juan Sprinkle*

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.