

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044696
STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 172

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

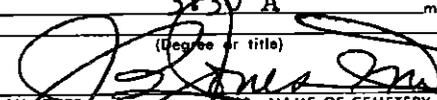
ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED NOV 20 1963

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Macon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LaPlata</u> | | c. CITY OR TOWN <u>Kirksville,</u> | |
| Length of stay in 1b <u>2 weeks</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <u>Route # 2</u> | | d. STREET ADDRESS (If outside, give location) <u>Route # 5</u> | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARITY AGNES WATSON</u> | | | 4. DATE OF DEATH Month Day Year <u>November 8 1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. RELIGION <u>Widowed</u> | 8. DATE OF BIRTH <u>8/10/75</u> |
| 9. AGE (last birthday) <u>88</u> | | 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) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11. BIRTHPLACE (City and state or country) <u>Adair County, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U S</u> | | 13a. FATHER'S NAME <u>George W. Dunham</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Christina Strunk</u> | | 14. NAME OF HUSBAND DECEASED <u>H. A. 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 <u>John D. Watson, Kirksville, Mo.</u> | | Address | |
| 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>Cerebral hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 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) | | | PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" 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>8-23-58</u> to <u>10-24-63</u> and last saw her <u>alive</u> on <u>10-24-63</u> Death occurred at <u>3:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE  | | 22b. ADDRESS <u>Kirksville, Mo.</u> | 22c. DATE SIGNED <u>11-9-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL TO OTHER PLACE <u>Burial</u> | 23b. DATE <u>11/10/63</u> | 23c. NAME OF CEMETERY OR CREMATORIA <u>East Center</u> | 23d. LOCATION (City, town, or county) (State) <u>Adair County, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>11-16-63</u> | 26. REGISTRAR'S SIGNATURE <u>Paul M. Neely</u> | |

USE BLACK INK
OR
TYPEWRITER RIBBON

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 *Rosa E Foster*

Licensed Embalmer No. 4742

P. O. Address *Fukerville, Pa*

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.