No.
—8-43
6-17-39
X37023

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41899

Registration District No. 249 Primary Registration District No. 3791 5792 Registrar's No. 2

1. PLACE OF DEATH:
(a) County Moniteau Co.
(b) City or town Rural - 1 mi E. of High Point Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Harrison Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 1010 E 41 st Kansas City Mo. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Henry Watts

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife Lela Watts
6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 9 1890 (Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Cole Co Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Garment Cutter

11. Industry or business

FATHER
12. Name John Boon
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Alice Sappingfield
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lela Watts
(b) Address 1010 E 41 st Kansas City Mo.

17. (a) Burial (b) Date thereof 12 24 1945 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Pleasant

18. (a) Signature of funeral director Flagg & Spring Bus
(b) Address Hugh E. Hilbrick California Mo.

19. (a) 1/10/46 (b) Chas H Hall (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 22 year 1945 hour 2 PM minute M.

21. I hereby certify that I attended the deceased from April 1945 to 12-22 1945 that I last saw him alive on 12-22 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor — Duration 8 mo

Due to

Due to

Other conditions Hypertension (Include pregnancy within 3 months of death) — 3 yrs

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature E C Shelton (M. D. or other)
Address Eldon Mo Date signed 12 24 45

1672 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 1-14-46

JAN 21 1946

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 ______________________________, Registered Apprentice No. ______ working under my personal supervision.

Signed Hugh E. Williams

Licensed Embalmer No. 3537

P. O. Address California 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 this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4899

Registration District No. 219 Primary Registration District No. 5792 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Moniteau
(b) City or town Rural - Harmony
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wm H. Watts
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 9 188[illegible] (Month) (Day) (Year)
8. AGE: Years 55 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 4-22-46 (Date received local registrar) (b) C.H. Gail (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 2
year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY