

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

24 1929  
 6 9  
 DEATH IS VERY IMPORTANT  
 EMPLOYER  
 DEPT. OF HEALTH  
 ST. JOSEPH, MO.  
 1929

PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township \_\_\_\_\_ Primary Registration District No. 1001  
 City ST JOSEPH (No. MO MET HO DIST HOSP.) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. 17325  
 Registered No. 623

2. FULL NAME JESSIE R WATKINS.  
 (a) Residence. No. Agency mo St. \_\_\_\_\_ Ward. Agency mo  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 23 da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ANNIE M WATKINS.  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) AUG 17, 1849  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 8 25  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work FARMER  
 (b) General nature of industry, business, or establishment in which employed (or employer) RETIRED / YEAR  
 (c) Name of employer \_\_\_\_\_  
 9. BIRTHPLACE (CITY OR TOWN) Buchanan  
 (STATE OR COUNTRY) mo.

PARENTS

10. NAME OF FATHER HENRY WATKINS  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN  
 12. MAIDEN NAME OF MOTHER POWELL  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

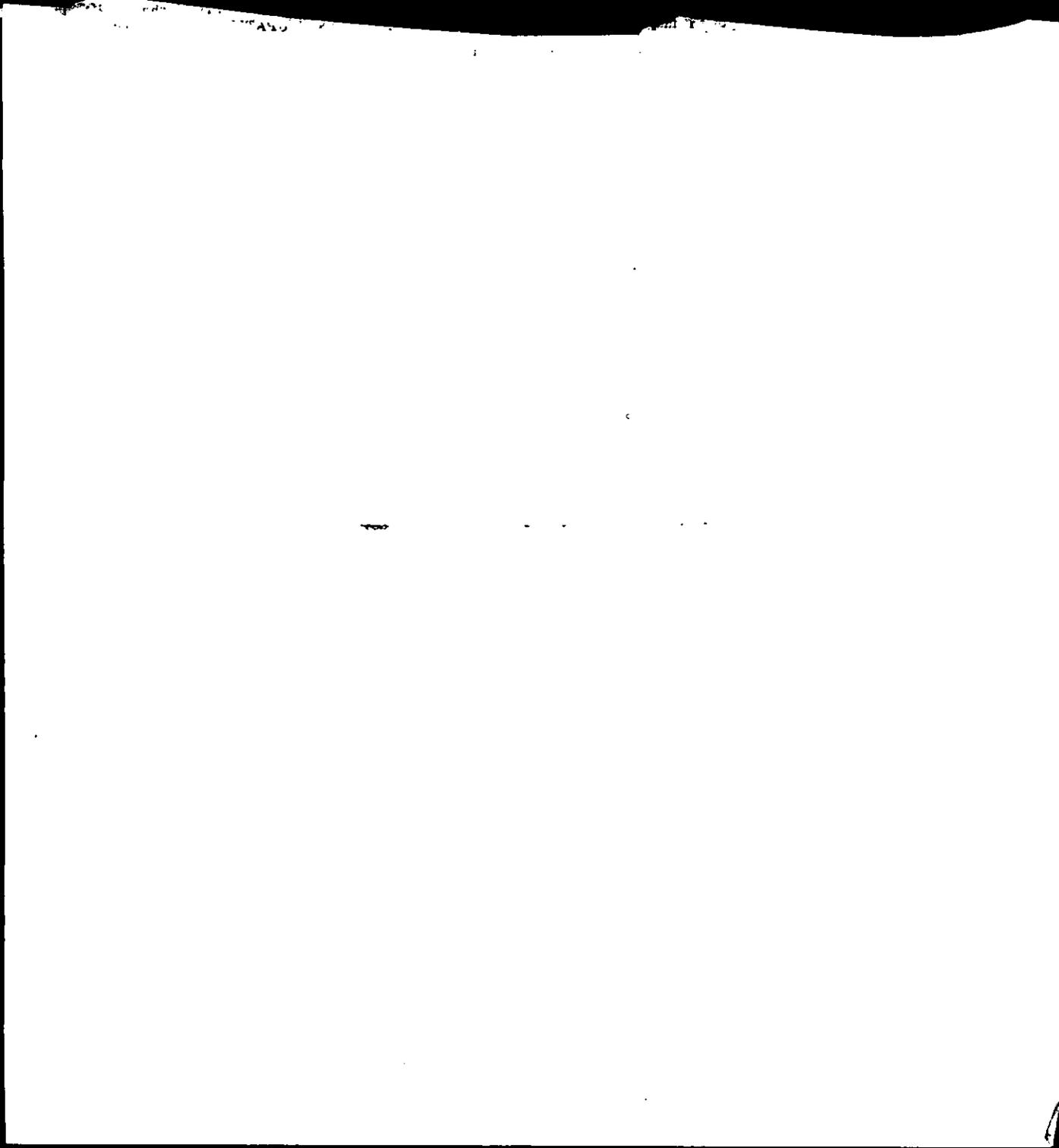
**MEDICAL CERTIFICATE OF DEATH**

4  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1929  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1929, to May 12, 1929, that I last saw him alive on May 12, 1929, and that death occurred, on the date stated above, at 10 P. m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia (lobar)  
515  
137  
108 (duration) yrs. mos. 2 da.  
 CONTRIBUTORY (SECONDARY) (Removal prostate gland)  
Carcinoma of bladder (duration) yrs. 6 mos. da.  
 18. WHERE WAS DISEASE CONTRACTED  
1144 IF NOT AT PLACE OF DEATH Fairfax mo  
 DID AN OPERATION PRECEDE DEATH? yes DATE OF May 7/29  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Physical examination  
 (Signed) J. J. Thompson, M. D.  
May 12, 1929 (Address) 825 Charles

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT W. W. WATKINS  
 (Address) 1519 Farnon  
 15. FILED 73 1929  
John C. [Signature] REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL 706 Cemetery DATE OF BURIAL May 14 1929  
 20. UNDERTAKER Lucian Davis ADDRESS Newborn Mo



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Buchanan

Registration District No. 85

File No. 623

Township .....

Primary Registration District No. 1001

Registered No. ....

City St. Joseph (No. ....) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

m.

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

w

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17 - 1899

7. AGE

79 YEARS

8 MONTHS

25 DAYS

IF LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED 7-10-1929

John G. [Signature]  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h. .... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is very important. REGISTRY CARDS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-17325