

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

Do not use this space.

16768

File No. _____
Registered No. 141
St. 6 Ward

1. PLACE OF DEATH
64 County Marion Registration District No. 547
1 Township Marion Primary Registration District No. 3029
8 City Hannibal (No. 123 Summer St. _____ Ward)

2. FULL NAME Francis Jane Watkins
(a) Residence No. 123 Summer St. 6 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 15-1932

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
				<u>9</u>

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) Hannibal (STATE OR COUNTRY) Mo

10. NAME OF FATHER James E. Watkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Mo

12. MAIDEN NAME OF MOTHER Ella Mae Mann

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Frankford Mo

14. INFORMANT Mr. Geo. E. Watkins (Address) Hannibal Mo.

15. FILED May 8 1932 of Cause REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1932

17. I HEREBY CERTIFY, That I attended deceased from birth to death that I last saw h. alive on May 15 1932 and that death occurred, on the date stated above, at 6:18 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth:

15/1 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 157 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (1)
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) E. P. Motter 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 St. Olive Cemetery DATE OF BURIAL 5-16-1932

20. UNDERTAKER James O'Donnell ADDRESS Hannibal Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 may be properly classified. Exact statement of OCCUPATION is very important.

JUN 23 1932

