

Ch. Shanks

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

111454
Do not use this space.

REC'D APR 21 1938

1. PLACE OF DEATH

(a) County Marion Registration District No. 527

(b) Township Mason Primary Registration District No. 3079

(c) City Hannibal (d) Street No. 715 Dycamore Registered No. 96

(e) Length of residence in city or town where death occurred 37 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clizabeth Katharine Watts 320

(a) Residence, No. 715 Dycamore St. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 18-1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>62</u>	<u>11</u>	<u>28</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 16-1938

22. I HEREBY CERTIFY, That I attended deceased from Mar 2, 1938, to Mar 16, 1938

I last saw him alive on Mar 16, 1938. Death is said to have occurred on the date stated above, at 7:20 P.M.

The principal cause of death and related causes of importance were as follows:

Psychitis
General Infection of
Kidney

Date of onset Mar 10

Other contributory causes of importance: Kidney stone

1344

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) A. L. Shanks, M. D.

(Address) Hannibal Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New London Mo.

FATHER

13. NAME William Y. Jones

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville Kentucky

MOTHER

15. MAIDEN NAME Cary Hemmings

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hempsville Kentucky

17. INFORMANT (ADDRESS) Samuel Watts
Hannibal Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet Cem. DATE Mar 19-1938

19. FUNERAL DIRECTOR (ADDRESS) W. Schmitt
Hannibal Mo.

20. FILED 3/29, 1938 W. W. Fisher
Local Registrar.

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.

1 X12004

STATEMENT BY LICENSED EMBALMER

I, Ray R. Schwartz, Licensed Embalmer No. 1765
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Ray R. Schwartz
No. 1765 or by Ray R. Schwartz L. E. Registered Apprentice No.
working under my personal supervision. Signed Ray R. Schwartz
Licensed Embalmer No. 1765

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.)