

MAY 15 1940 791

1003

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
In this community 10 years
years, months or days

8. (a) PRINT FULL NAME DELIA WATKINS 325

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

4. Sex FEMALE 5. Color or race Negro 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife HERMAN WATKINS 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased: (Month) 1 (Day) 20 (Year) 1896

8. AGE: Years 44 Months 2 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Humboldt Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation DOMESTIC

11. Industry or business _____

12. Name FRED Dunlap

13. Birthplace Tenn. (City, town, or county) (State or foreign country)

14. Maiden name Clay Jones

15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant Mixie Dunlap

(b) Address 316 S. 16th St.

17. (a) Burial (b) Date thereof 4-6-40 (Month) (Day) (Year)

(c) Place: burial or cremation Humboldt Tenn.

18. (a) Signature of funeral director LUCINDA THOMAS

(b) APR 6 1940 (Date received local registrar)

19. (a) _____ (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town St Louis Mo 22
(If outside city or town limits, write "RURAL")
(d) Street No. 103 So 16th
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st
year 1940 hour 3:30 minute 4 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Traumatic Subdural Hemorrhage, contused, associated
Due to wound of forehead
Time: Back Gun & Manner
Due to same should not be determined

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 near about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] Address [Signature] Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, ~~only~~.....

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

Signed C. L. Howell.....

Licensed Embalmer No. 2452.....

P. O. Address 2820 Dickson.....

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, above space should be left blank.