

NOV 14 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

NOV 14 1940

35168

State File No.

Registration District No.

248

Primary Registration District No.

5-344

Registrar's No.

1. PLACE OF DEATH:

(a) County Daviess
(b) City or town "Rural" Liberty Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Months
(Specify whether
In this community 7 Months
years, months or days)

3. (a) PRINT FULL NAME Charles Ray Watkins

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife ***** 6. (c) Age of husband or wife if alive 8 years

7. Birth date of deceased April 8 1935
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 5 18 hr. min.

9. Birthplace Daviess County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business At Home

12. Name Clay Watkins

13. Birthplace St. Clair Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Almira F. Clutter

15. Birthplace Harrison Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clay Watkins

(b) Address Gallatin, Mo.

17. (a) Burial (b) Date thereof 9-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gilman City, Mo.

18. (a) Signature of funeral director Hopewell Funeral Co.

(b) Address Gallatin, Mo.

19. (a) 9-30-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess
(c) City or town "Rural" Liberty Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. 3 Miles S.W. Gallatin, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1940 hour 11 minute 00 A.M.

21. I hereby certify that I attended the deceased from Sept 1st
1940 to Sept 26th 1940
that I last saw him alive on Sept 20th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Stk. Boreama
Rght. Shoulder arm

Due to 12 month

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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?

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

23. Signature J. B. Graham (M.D. or other)

Address Jackson, Mo. Date signed 9-27-40

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

MOTHER FATHER

201

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed L. O. Rickesson

Licensed Embalmer No. 3302

P. O. Address Gallatin, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35-168

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 248

Primary Registration District No. 5344

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Davess
(b) City or town Liberty
(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) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Charles Ray Walkers

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Sept day 26
year 1940 hour _____ minute _____ M.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced s

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.

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

Immediate cause of death Osteo Sarcoma

7. Birth date of deceased (Month) (Day) (Year)

Rt shoulder and arm

8. AGE: Years Months Days If less than one day
5 5 18 hr _____ min _____

Due to Septic
Due to Septic

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

Other conditions Humeral physisal
(Include pregnancy within a month of death)

10. Usual occupation

Major findings: Humeral physisal
Operations Sept 13 1940

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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?

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

23. Signature J.P. G. [unclear] (M. D. or D.O.)

Address Davess Mo Date signed 10/25/40

SUPPLEMENTAL

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

