

S. No. 2  
M-9-4-41  
Rev. 5-17-39  
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9309

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED APR 7 1945

Registration District No. 7

Primary Registration District No. 3008

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Stanton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital no 19  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 years 16 days  
(Specify whether years, months or days)

In this community named

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Dixon  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SPURGEON WATKINS

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 14 1916  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

28	2	24	hr. _____ min.
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9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farm Boy

11. Industry or business \_\_\_\_\_

12. Name J. A. Watkins

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

14. Maiden name Jean Stein

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

16. (a) Informant Records State Hospital no 1

(b) Address Stanton Mo

17. (a) Removal (b) Date thereof Mar. 10 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixon, Mo

18. (a) Signature of funeral director Allen Y. Manning

(b) Address 912 Court St. Fulton, Mo.

19. March 10 1945 (Date received local registrar) Joie Missouri Hoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1945 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from Feb 1 1945 to March 10 1945 that I last saw him alive on March 9 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia

Due to: Chronic Pneumonia

Due to: Septic Precip

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 109

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 in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_

(b) Means of injury car

23. Signature George W. Lewis (M.D. or other) \_\_\_\_\_

Address Fulton Mo Date signed 3/10/45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

14  
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-6-45

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

Signed Glen Y. Mangin

Licensed Embalmer No. 2725

P. O. Address Fulton, 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, fact should be so stated above.