

3. No. 2
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5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40944**

FILED JAN 8 1946

Registration District No. **12**

Primary Registration District No. **3013**

Registrar's No. **108**

1. PLACE OF DEATH:

(a) County Clay
(b) City or town North Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 13th + Burlington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution years
(Specify whether years, months or days)
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay
(c) City or town North Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 13th + Burlington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DENNIS WATKINS

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

4. Sex MA 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 _____ years

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

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

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

10. Usual occupation shoemaker

11. Industry or business Elliott Construction Co

MOTHER FATHER
12. Name unknown
13. Birthplace (City, town, or county) (State or foreign country) unknown
14. Maiden name unknown
15. Birthplace (City, town, or county) (State or foreign country) unknown

16. (a) Informant records in his room

(b) Address _____

17. (a) Burial (b) Date thereof 12/22/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty - Mrs. Morton Funeral Home

18. (a) Signature of funeral director W. H. G. M.D.

(b) Address _____

19. (a) Dec 22 - 1945 (b) Beulah Kitchin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 9 year 1945 hour 10 minute A 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 Coronary Thrombosis
Due to also body frozen

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

Major findings: Of operations _____ Of autopsy 940

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? _____

While at work (Specify type of place) _____ (a) Means of injury Coronary

23. Signature John K. Mott (M.D. or other) _____
Address North Kansas City, Mo Date signed 12/22/45

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-2-46.....

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.....

John J. Martin

Licensed Embalmer No.

~~434~~ 434

P. O. Address.....

no address

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.

Registration District No. 26 72

Primary Registration District No. 3013

1. PLACE OF DEATH:

(a) County Clay
(b) City or town North Kansas city
(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

3. (a) PRINT FULL NAME Dennis Watkins

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

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

8. AGE: approx 65 Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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 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 _____ (M. D. or other)

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

40944