14

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1946

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STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5318

Registration District No. 128 | Primary Registration District No. 5466 | Registrar's No. 196

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

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Rural, S. Campbell Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ozark Osteopathic Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Polk 84
(c) City or town: Rural Bolivar 0
(If outside city or town limits, write "RURAL")
(d) Street No.: Rt. 1 Bolivar Mo.
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Floyd Columbus Watkins
3. (b) If veteran, name war: KOREA
3. (c) Social Security No. 497-22-5958

4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nellie Watkins
6. (c) Age of husband or wife if alive: 20 years
7. Birth date of deceased: Dec. (Month) 5 (Day) 1921 (Year)

8. AGE: Years 24 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Cliquot (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Truck driver
11. Industry or business: milk route

MOTHER / FATHER
12. Name: T. T. Watkins
13. Birthplace: Polk County (City, town, or county) Mo. (State or foreign country)
14. Maiden name: Nellie Rukes
15. Birthplace: Cooper County (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Mrs Nellie Watkins
(b) Address: Rt. 1 Bolivar Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 28 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Salem Cemetery
18. (a) Signature of funeral director: Hutchesson - Turpin
(b) Address: Bolivar Mo.
19. (a) 2-26-46 (Date received local registrar) (b) O. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25 year 1946 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from FEB 8, 1946, to FEB 25, 1946, that I last saw him alive on FEB 25, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia

Due to ____

Due to ____

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

Major findings:
Of operations ____
Of autopsy ____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature: R. C. Michael D.O. (M.D. or other)
Address: Springfield Mo. Date signed 2-25-46

111

(Licensed Embalmer's Statement on Reverse Side)

NOV 13 1948

NOV 9 1948

OCT 4 1948

OCT 25 1948

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.....

Licensed Embalmer No. 2053

P. O. Address Bolivar, 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.

No. 2B
3-45
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 158 Primary Registration District No. 5 X 6 4 Registrar's No. 196

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Floyd C. 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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 5 (Day) 1922 (Year)
8. AGE: Years 24 Months 2 Days 0 If less than one day hr. min.
9. Birthplace (City, town, or county) MO (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 25 year 1946 hour minute 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 Uremia
Due to Chronic glomerulo-nephritis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 130

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature K. C. Michael M.D. (M. D. or other)
Address Springfield, Mo Date signed 7-19-46

SUPPLEMENTARY

LEGAL SUPPLEMENTARY INFORMATION REQUESTED

431A WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5318