DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14644

Registration District No. 2 1 1 Primary Registration District No. 3056 Registrar's No. 103

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wabash Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Four days (Specify whether
In this community years, months or days) Four Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain 4
(c) City or town Martinsburg 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Charles Fredrick Watkins
3. (b) If veteran, name war None
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maggie Watkins
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased October (Month) 15 (Day) 1875 (Year)

8. AGE: Years 71 Months 6 Days 5 If less than one day hr. min.

9. Birthplace Pendleton (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Track Supervisor
11. Industry or business Wabash
FATHER
12. Name Fred Watkins 4
13. Birthplace London (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name Sarah Robinson 0
15. Birthplace Troy (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Harley League
(b) Address Mexico Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr (Month) 22 (Day) 47 (Year)
(c) Place: burial or cremation Unity Cemetery Audrain Co. Mo.
18. (a) Signature of funeral director Snow Funeral Home
(b) Address Moberly Missouri
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th year 1947 hour 9:30 minute A. M.
21. I hereby certify that I attended the deceased from 4/14, 1947 to 4/20, 1947 that I last saw him alive on 4/20, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial failure	4 Days
Due to Arteriosclerosis, general. Prostatic hypertrophy	
Due to malignancy	
Other conditions (Include pregnancy within 3 months of death) Prostatic hypertrophy due to malignancy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations None
Of autopsy None. 51B

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 0
23. Signature [signature] (M. D. or other)
Address Moberly Mo Date signed 20/4/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAY 15 1947
District Health Officer No
District File Number 4-47-
APR 28 1947
Date Filed

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 R. M. Cater

Licensed Embalmer No. 4117

P. O. Address Moberly Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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. 294 Primary Registration District No. 3056 Registrar's No. 103

1. PLACE OF DEATH
(a) County Randolph
(b) City or town Moberly
(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 Charles F. 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
7. Birth date of deceased Oct 15 (Month) (Day) (Year)
8. AGE: Years 71 Months 6 Days Hours Minutes
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) 4-22-47 (Date received local registrar) (b) Carl William Lewis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 20 year 1947 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	Duration
Myocardial failure	4 days
Due to Arteriosclerosis general	
Due to	
Other conditions Prostatic hypertrophy due to malignancy - Cancer (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
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While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5/13

14044