

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6794
1383

Registrar's No.

BIRTH NO. 49-005228 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY 16	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau 11	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Deaconess Hospital 1		d. STREET ADDRESS (If rural, give location) ?	

3. NAME OF DECEASED (Type or Print) Thomas Watkins			4. DATE OF DEATH (Month) (Day) (Year) 2 - 7 - 49		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 1-14-49		9. AGE (In years last birthday) 7	10. UNDER 1 YEAR Months	11. UNDER 1 MIN. Hours	12. UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U Deaconess Hospital, St. Louis		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Denzel Watkins		13b. MOTHER'S MAIDEN NAME Mildred Trickey Watkins		14. NAME OF HUSBAND OR WIFE Denzel Watkins	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atresia of the bowel. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 1-15-49 DUE TO (c) 7-5-49		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 1-15-49	19b. MAJOR FINDINGS OF OPERATION Atresia of the bowel.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 1-15-49, 19, to 2-7-49, 19, that I last saw the deceased alive on _____, 19, and that death occurred at 1030 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Beau Sauer M.D.	23b. ADDRESS #916 Missouri Theatre Bldg. St. Louis, Missouri	23c. DATE SIGNED 2-10-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-9-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Cape Girardeau Mo
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DATE REC'D BY LOCAL REG. FEB 14 1949	REGISTRAR'S SIGNATURE J. Beasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Sam M. Simon

Signed _____
Student Embalmer

Licensed Embalmer No. _____

04343

P. O. Address _____

St. Louis 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.