

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41981

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 282 PRIMARY REG. DIST. NO. 3055 Registrar's No. 140

841

1. PLACE OF DEATH  
a. COUNTY Polk

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission).  
a. STATE Missouri b. COUNTY Polk

b. CITY OR TOWN Bolivar c. LENGTH OF STAY (In this place) 7 yrs.  
c. CITY OR TOWN Bolivar d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION 624 South Mill St e. STREET ADDRESS (If rural, give location) 624 South Mill St <sup>0841</sup>

3. NAME OF DECEASED (Type or Print)  
a. (First) Mary b. (Middle) Frances c. (Last) Watkins

4. DATE OF DEATH (Month) (Day) (Year) Dec 10 1954

5. SEX F 6. COLOR OR RACE wh 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Sept 22 1872 9. AGE (In years last birthday) 82 if UNDER 1 YEAR Months 2 Days 18 if UNDER 10 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY Housework 11. BIRTHPLACE (City and State or Foreign Country) Near Clewish Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Crawford 13b. MOTHER'S MAIDEN NAME Amund Torrey 14. NAME OF HUSBAND OR WIFE James Alonzo Watkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME (Address) James Alonzo Watkins Bolivar Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Cerebral Apoplexy MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 days  
ANTECEDENT CAUSES  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS Chronic hypertension  
Conditions contributing to the death but not related to the disease or condition causing death. myocarditis 2 yrs

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION 3.34 X # 20. AUTOPSY? YES  NO

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) \_\_\_\_\_

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from Dec 1952, to Dec 10 1954, that I last saw the deceased alive on Dec 10, 1954 and that death occurred at 7:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D C McLean M.D. 23b. ADDRESS Bolivar Mo 23c. DATE SIGNED 12-17-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Dec 12/54 24c. NAME OF CEMETERY OR CREMATORY Salem Cemetery 24d. LOCATION (City, town, or county) (State) Near Clewish Mo

DATE REC'D BY LOCAL REG. 12-18-1954 REGISTRAR'S SIGNATURE Ralph ... FUNERAL DIRECTOR'S SIGNATURE Blue ... ADDRESS Bolivar Mo

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

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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..

Student.....  
Signature of Student Embalmer

Signed *Chas J. Ester*.....  
Licensed Embalmer No. *415*.....

P. O. Address *Bolivar*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.