

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1664

State File No.

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 470

1. PLACE OF DEATH a. COUNTY <u>Linn J. Watkins</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Russell twp. 0610</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney hospital 0</u>		d. STREET ADDRESS (If rural, give location) <u>7 mi. N. of New Cambria</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Watkin</u>	b. (Middle) <u>J. Watkins</u>	c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) <u>I-II-55</u>
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5. SEX <u>M. 0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>3-4-1875</u>	9. AGE (In years last birthday) <u>79</u>	10. UNDER 1 YEAR Months <u>10</u> Days <u>7</u>	11. UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Russell twp., Macon Co. 0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Thos. J. Watkins</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret</u>	14. NAME OF HUSBAND OR WIFE <u>Nola May Stinson</u>
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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) NO. _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Ruby Watkins, Ethel, Mo.</u>	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral hypostatic pneumonia</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Congenital heart lesion</u> DUE TO (c) <u>Myocarditis & Coronary atherosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Jan 11, 1955, to Jan 11, 1955, that I last saw the deceased alive on Jan 11, 1955, and that death occurred at 9:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. W. Bohm M.D. 0</u>	23b. ADDRESS <u>211 Basin Brookfield Mo</u>	23c. DATE SIGNED <u>1-11-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>I-14-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-15-55</u>	REGISTRAR'S SIGNATURE <u>Nadine Stambach</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Sallend</u> ADDRESS <u>New Cambria Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 4 1955

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 H. J. Gilleland

Signed _____
Student Embalmer

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.