

FILED JUL 5 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19375

BIRTH NO. _____		REG. DIST. NO. <u>187</u>		PRIMARY REG. DIST. NO. <u>3040</u>		Registrar's No. <u>118</u>	
1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. LENGTH OF STAY (In this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		0592 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Leeper Hotel</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BERT</u>			b. (Middle) <u>ALVIN</u>		c. (Last) <u>WATKINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 20 1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 9, 1882</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer and</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mailcarrier</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Dawn, Missouri (Liv Co)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John E. Watkins</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine E. Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Grace Glick</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>487-14-7909</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Opal Grace Mantziy Dawn, Missouri</u>			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Vremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <u>Congestive heart failure</u>			<u>?</u>
				DUE TO (c) <u>Myocarditis</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>Asthma 4222</u>			<u>?</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 24, 1957</u> , to <u>June 20, 1955</u> , that I last saw the deceased alive on <u>June 20, 1955</u> , and that death occurred at <u>12:40 pm</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph F. Gale M.D.</u>				23b. ADDRESS <u>Chillicothe, Mo.</u>		23c. DATE SIGNED <u>6-21-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 22 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Welch Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Dawn (Liv Co) Mo.</u>			
DATE REC'D BY LOCAL REG. <u>6/21/55</u>		REGISTRAR'S SIGNATURE <u>Frances B. Neill 171</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>NORMAN FUNERAL HOME Chillicothe, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Joseph M. Gibson
Licensed Embalmer No. 4769

P. O. Address Chillicothe, 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.