

Health,
& Welfare
S. Public
Hh Service

S. 300
ev. 1-56

Securing the medical certification in the specific manner required by §§ 140 MO RS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38891
STATE FILE NUMBER

FILED OCT 31 1957

Registration District No. 391 Primary Registration District No. 6153 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY STODDARD			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY STODDARD		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN RURAL		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BELL CITY #1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) BELL CITY RD 1		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLARENCE Middle PRICE Last WATKINS			4. DATE OF DEATH Month 10 Day 8 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1906		9. AGE (In years last birthday) 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) SENATH MO		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN WATKINS			14. MOTHER'S MAIDEN NAME ETHEL BIGGS		
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. 333-14-0467	17. INFORMANT Address Mrs. Herculine Watkins - Bell City MO		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct					INTERVAL BETWEEN ONSET AND DEATH at once
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Hypertensive heart disease					8-10 years
DUE TO (c)					2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from July 1948 to Oct. 8, 1957 and last saw her/him alive on 12-7-57 Death occurred at 12:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) H. B. Proymortor M.D.			22b. ADDRESS Sikeston, MO.		22c. DATE SIGNED 14-Oct-57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-12-1957	23c. NAME OF CEMETERY OR CREMATORY FORREST HILL MEM. GARDENS -		23d. LOCATION (City, town, or county) (State) SCOTT CO MO
24. FUNERAL DIRECTOR Welsh Funeral Home - Sikeston MO		25. DATE RECD. BY LOCAL REG. 10/23/57		26. REGISTRAR'S SIGNATURE Dorris Moore	

(Licensed Embalmer's Statement on Reverse Side)

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..... *Raymond Crews*

Licensed Embalmer No. *346*

P. O. Address *Sikeston*

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.