

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015911

STATE FILE NUMBER

Registration No. 3497

FILED APR 24 1959

Registration District No. Primary Registration District No.

300
-57

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Bloomington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>St Louis Little Rock</u> INSTITUTION <u>Hosp Inc</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>819 Mill Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Earl</u> Last <u>Watkins</u> | 4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>59</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 11, 1894</u> | 9. AGE (In years last birthday) <u>64</u> | IF UNDER 1 YEAR Months Days | IF 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>Machinist</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | 11. BIRTHPLACE (City and state or country) <u>Chandlerville, Illinois.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Allen Watkins</u> | 13b. MOTHER'S MAIDEN NAME <u>Carolyn Gerdes</u> | 14. NAME OF HUSBAND OR WIFE <u>Delia</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year no. or unknown) (If yes, give year or dates of service) <u>No.</u> | 16. SOCIAL SECURITY NO. <u>709,12,1951</u> | 17. INFORMANT <u>Mrs. Delia Watkins, 819 Mill, St.</u> | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma Generalized Left Pleural Effusion</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriosclerotic Heart Disease Decompensated</u> | |
| | DUE TO (c) <u>Arteriosclerosis Generalized</u> <u>200.1</u> | |
| 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"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year 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 |
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| 21. I attended the deceased from <u>March 24, 59</u> to <u>April 7, 59</u> and last saw ^{him} her alive on <u>April 7, 59</u> Death occurred at <u>9,10 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) | 22b. ADDRESS <u>1755 So Grand</u> | 22c. DATE SIGNED <u>4-7-59</u> |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>5-9-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Park Hill Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Bloomington, Illinois.</u> |
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| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u> | 25. DATE RECD. BY LOCAL REG. <u>APR 8 '59</u> | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> <u>M.D.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Robert M. Murray*

Licensed Embalmer No. *37490*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.