

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 15 1960

60-000683
60-000683
STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. _____ Registrar's No. 15

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CHARITON</u>	a. STATE <u>MISSOURI</u>		b. COUNTY <u>CHARITON</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BRUNSWICK TWP. FEW HOUR</u>	Length of stay in 1b <u>FEW HOURS</u>	c. CITY OR TOWN <u>BRUNSWICK</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 MILE N.W. BRUNSWICK</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>712 W. BROADWAY</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>CHARLES</u>	Middle <u>JACOB</u>	Last <u>WATKINS</u>	4. DATE OF DEATH	Month <u>JAN.</u>	Day <u>8</u>	Year <u>1960</u>
-------------------------------------	-------------------------	------------------------	------------------------	------------------	----------------------	-----------------	---------------------

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>SEPT. 27 1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CITY MAIL CARRIER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED MAIL CARRIER</u>	11. BIRTHPLACE (City and state or country) <u>BRUNSWICK, MISSOURI</u>	12. CITIZEN OF WHAT <u>U.S.A.</u>
---	--	--	--------------------------------------

13a. FATHER'S NAME <u>BOYD WATKINS</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH TURNER</u>	14. NAME OF HUSBAND OR WIFE <u>ROSETTA SMITH WATKINS</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>499-40-3195</u>	17. INFORMANT <u>NORMAN WATKINS, BRUNSWICK, MO.</u>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Internal injuries accidental</u>		<u>Instantly</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Falling on head and shoulder</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <u>(over)</u>
--	---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>on his farm</u>	20f. CITY, TOWN, OR LOCATION <u>4 miles N.W. of Brunswick, Chariton Co. Brunswick, MO</u>
---	--	--

21. I attended the deceased from <u>Death on arrival Jan 8-60</u> and last saw her alive on <u>Jan 8-60</u>	her death occurred at <u>9:30</u> on the date stated above, and to the best of my knowledge, from the causes stated.
---	--

22a. SIGNATURE <u>Shouler C. Rice</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Brunswick, MO.</u>	22c. DATE SIGNED <u>Jan 10-1960</u>
---	---------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN. 10, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELLIOTT GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>BRUNSWICK MISSOURI</u>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <u>Harold F. H., Brunswick, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 11-1960</u>	26. REGISTRAR'S SIGNATURE <u>Lois Smith</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

P.S.

This man was killed accidentally when a tree
was driving on a work project near away
ing him with his head striking the wagon
He was dead on my arrival but was still warm
dead I decided his death was instantaneous

Grover C. Rice, M.D.

GROVER C. RICE M.D.

VS FEB 20 19

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William R. Koc

Licensed Embalmer No. 4751

P. O. Address Brunswick

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.