

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013813

FILED VS APR 11 1960

STATE FILE NUMBER

Registration District No. 325 Primary Registration District No. 4480 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Schuyler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greentop Mo</u>	Length of stay in 1b	c. CITY OR TOWN <u>Lancaster Mo</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>Greentop Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>David</u> ^{First} <u>William</u> ^{Middle} <u>Watkins</u> ^{Last}			4. DATE OF DEATH Month <u>Mar</u> Day <u>31</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 22, 1866</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Schuyler Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>George W Watkins</u>		13b. MOTHER'S MAIDEN NAME <u>Tabitha Searcy</u>		14. NAME OF HUSBAND OR WIFE <u>Mary K. Watkins</u>	
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. <u>No</u>		17. INFORMANT <u>Wilson Watkins</u> Address: <u>Lancaster Mo</u>	

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>Inanition</u>			<u>6 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Gastric Hemorrhage</u>		<u>3 mo.</u>
	DUE TO (c) <u>Gastric Antral Carcinoma</u>		<u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arthritis</u>			PART III. If deceased was female was 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 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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>9/15/59</u> to <u>3/31/60</u> and last saw him alive on <u>3/31/60</u>	COUNTY <u>Queen City Mo.</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>5:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE (Degree or title) <u>David M. Roberts, M.D.</u>		22b. ADDRESS <u>Queen City Mo.</u>		22c. DATE SIGNED <u>4/4/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr 2 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood I.O.O.F.</u>	23d. LOCATION (City, town, or county) (State) <u>Glenwood Mo</u>	
24. FUNERAL DIRECTOR <u>Norman's</u> ADDRESS <u>Lancaster Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-2-1960</u>	26. REGISTRAR'S SIGNATURE <u>W. B. J. Drake</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

David L. Foster

Licensed Embalmer No. *4742*

P. O. Address *Fulkville, Md*

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.