

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-002107

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 97

AMENDED

FILED JAN 18 1962

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 25 yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5409 Anderson Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Jackson
 c. CITY OR TOWN Kansas City Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 5409 Anderson Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Charles Hugh Watkins 4. DATE OF DEATH Month Day Year 1 5 1962

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 5/20/1905 9. AGE (last birthday) 56 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) welder 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (City and state or country) Boxscho, Okla 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Robert Watkins 13b. MOTHER'S MAIDEN NAME Olive Harrower 14. NAME OF HUSBAND OR WIFE Marquette Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 17. INFORMANT Marquette Watkins Address R.C., Mo

18. CAUSE OF DEATH (Enter only one cause per line for terminal disease condition given in PART I (a))
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Lobar Pneumonia
 DUE TO (b) _____
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cough several days
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ruth A Owens 22b. ADDRESS 152 Union Station 22c. DATE SIGNED 1-8-62

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 23b. DATE 1/8/1962 23c. NAME OF CEMETERY OR CREMATORY mt. Washington 23d. LOCATION (City, town, or county) (State) Independence, Mo

24. FUNERAL DIRECTOR C.N. Blackman & Son ADDRESS R.C., Mo 25. DATE RECD. BY LOCAL REG. 1-8-62 26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 Michael A. Davis

Licensed Embalmer No. 4888

P. O. Address PC 24, 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.