

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

32391

**1. PLACE OF DEATH**

County..... Registration District No. 781  
 Township..... Primary Registration District No. 1003  
 City..... (No. 7305 Virginia Ave. St. .... Ward)

File No.....  
 Registered No. 9489  
 St. .... Ward)

**2. FULL NAME** Charles J. Watkins

(a) Residence. No. 7305 Virginia Ave. St. 1 Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Watkins

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 16 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 7 5

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) Furniture Dealer  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Pennsylvania

10. NAME OF FATHER James Watkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wales

12. MAIDEN NAME OF MOTHER Hannah Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Wales

14. INFORMANT Chas R. Watkins  
 (Address) 7305 Virginia Ave

15. FILED Oct. 21 1929 W.C. Stanley REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 21 1929

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to Sept 21, 1929 that I last saw him alive on Sept 21, 1929, and that death occurred, on the date stated above, at 2:45 P.M. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral Haemorrhage  
82A  
97

CONTRIBUTORY (SECONDARY) Active Rheumatism (duration) 4 yrs. 4 mos. 4 ds.  
 (duration) 10 yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? No. DATE OF.....  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS Thyroid  
 (Signed) Carl W. [Signature], M. D.  
 , 19 (Address) 616 Ins Theater Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Mausoleum DATE OF BURIAL 9-24 1929

20. UNDERTAKER Southern ADDRESS 7315 S. Broadway

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