

Registration District No. **677**

Primary Registration District No. **4403**

1. PLACE OF DEATH:

(a) County **Shelby**
(b) City or town **Maeda**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Melle M. Garland Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dent**
(c) City or town **Salem**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME **James W. Watkins**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **MARY** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 17 1867**
(Month) (Day) (Year)

8. AGE: Years **72** Months **7** Days **17** If less than one day _____ hr. _____ min.

9. Birthplace **Habeon Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Hudson Watkins**

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Margery Bailey**

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Geo. H. Watkins**
(b) Address **Salem Mo**

17. (a) **burial** (b) Date thereof **Feb 6, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **partly cem.**

18. (a) Signature of funeral director **Paul Owen**
(b) Address **Rolla Mo**

19. (a) **Feb 6, 1940** (b) **Jos. F. Myers**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **4** in year **1940** hour **2** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Jan 30** 19**40**, to **Feb 4** 19**40**, that I last saw him alive on **Feb 3** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Influenza** Duration _____

Due to _____

Due to **11/10**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Paul Owen** (M.D. or other) _____
Address **Rolla Mo** Date signed **2/9/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 240 227

Date Filed 2/6/40

Signed.....

S. L. Muel

Licensed Embalmer No. 3397

P. O. Address Reeemo

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 this body is not embalmed, above space should be left blank.