

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24

Registrar's No. 24

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

FILED OCT 5 - 1943  
Registration District No. 288

Primary Registration District No. 5981

32320  
32320  
24

1. PLACE OF DEATH: Polk  
(a) County Polk  
(b) City or town Rural  
(c) Name of hospital or institution: Walter Watkins  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Polk  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN. WALTER WATKINS  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9-9 day \_\_\_\_\_  
year 43 hour 12 minute 30 P.M.  
21. I hereby certify that I examined the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased FEB. 17 1878  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Coronary Occlusion  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 70 Months 7 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace POLK COUNTY (City, town, or county) (State or foreign country) 0  
10. Usual occupation FARMER

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name JAMES. WATKINS  
13. Birthplace POLK COUNTY, MISSOURI  
(City, town, or county) (State or foreign country)  
14. Maiden name HULDA PICKLE  
15. Birthplace TENNESSEE  
(City, town, or county) (State or foreign country)

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? Home  
(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) \_\_\_\_\_  
Date of injury \_\_\_\_\_

16. (a) Informant HAZEL BERCHLER  
(b) Address SPRINGFIELD, MO 9-12-43  
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 43  
(Month) (Day) (Year)  
(c) Place: burial or cremation BRUSH GROVE  
18. (a) Signature of funeral director Nathan FCO  
(b) Address Bolivar, MO  
19. (a) 9-21-1943 (Date received local registrar) (b) Lucille Brown (Registrar's signature)

23. Signature Paul Fitts (M.D. or other) Cowan  
Address Bolivar, MO Date signed 9-18-43

OGT 5  
10-4-43

RE  
District File Number 9-45-962  
Date Filed 10-4-43

**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.

Signed.....  
Licensed Embalmer No.....  
P. O. Address.....

**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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 238

Primary Registration District No. 5987

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Rural Madison  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John Walter Watkins

3. (b) If veteran name was \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 17  
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 10 (If less than one day, \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Lucille Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I examined the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 sta-  
tistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1 22

32320