

Registration District No. 150

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural, Prairieville Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jack Co Emes Hosp 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community 73 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence 48
(If outside city or town limits, write "RURAL")
(d) Street No. 1500 N Liberty St 14
(If rural, give location) 4
(e) Citizen of foreign country? ! No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARATHA AGNES WATKIN

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

4. Sex fe 1 5. Color or race W 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Hollis Watkin 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Sept 18 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 3 If less than one day
hr. _____ min. _____

9. Birthplace Jackson Co Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Lendia Clayton

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Love

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lendia Newbank
(b) Address Clath, Mo.

17. (a) Burial (b) Date thereof Jan 18 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director Geo. B. Carson
(b) Address Independence Mo

19. (a) Jan 16, 1945 (b) F. M. Schickel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12
year 1945 hour 1:00 minute _____ A.M.

21. I hereby certify that I attended the deceased from Jan 22 1945 to Jan 12 1945
that I last saw h. alive on Jan 12 and that death occurred on the date and hour stated above. 45

Immediate cause of death Coronary thrombosis Duration 30 min

Due to _____

Due to _____

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

Major findings: Of operations g. p.

Of autopsy _____

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 Fred W. Hink (M. D. or other) _____
Address Guernsey, Mo. Date signed 1/15/45

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

18
00
00

MOTHER FATHER

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

1162

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. *4199*

P. O. Address *Independence, 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 this body is not embalmed, fact should be so stated above.