

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL RECORDS
FILED JUL 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 537

1. PLACE OF DEATH:

(a) County Lesane
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Springfield Baptist Hospital
(If not a hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 3 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ston 104
(c) City or town lesane 1
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? USA Cit (Yes or No)
If yes, name country _____

3. (a) PRINT

FULL NAME MINNIE ELLIS WATKINS

3. (b) If veteran, name war NONE 3. (c) Social Security No. UNK

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife U. H. WATKINS 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased AUG. 6, 1888
(Month) (Day) (Year)

8. AGE: Years 52 Months 10 Days 25 If less than one day hr. _____ min. _____

9. Birthplace BARRE CO. MO. (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name M. B. Ellis

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

14. Maiden name Elizabeth Wilson

15. Birthplace Barre co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Nita May

(b) Address 1406 1/2 N. Broadway, Springfield, Mo.

17. (a) Burial (b) Date thereof 6-31-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation lesane Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Marionville, Mo.

19. (a) 6-19-46 (b) 15 W 2 - Broad
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
year 1946 hour 10 minute 00 A. M.

21. I hereby certify that I attended the deceased from 11:10 June 19, 1946 to 19 June 19, 1946
that I last saw her alive on 19 June 19, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death:
1. Cerebral Embolism 1 day
2. Surgone left leg 2 weeks
Due to Subacute Bacterial endocarditis
Due to _____

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

Major findings:
Of operations amputation left leg (mid-thigh)
Of autopsy none

Duration

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 Fred R. Farthing (M. D. or other) 0
Address 446 Med Arts Bldg Date signed 19 June 1946

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

18888

111

36-1-
33

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..... *Herman Juridge*
Licensed Embalmer No. *3072*
P. O. Address..... *Aurora 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.

X