S. No. 2
M—5-42
. 5-17-39
PI X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33790

FILED NOV 3 1947

Registration District No. 42 | Primary Registration District No. 5134 | Registrar's No. 1278

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D # 5 - Washington Twsp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: / (Specify whether years, months or days)
In this community: Entire Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Buchanan
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: St Joseph R.F.D # 5
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Carrie - Watkins
3. (b) If veteran, name war: --
3. (c) Social Security No.: --
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: William Watkins
6. (c) Age of husband or wife if alive: 66 years
7. Birth date of deceased: Oct (Month) 23 (Day) 1884 (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	0	2	hr. min.

9. Birthplace: Buchanan Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: Peter Kline
13. Birthplace: Redding (City, town, or county) Penn (State or foreign country)
14. Maiden name: Mahala Thorp
15. Birthplace: -- (City, town, or county) Texas (State or foreign country)
16. (a) Informant: Miss Sophia Kline
(b) Address: 2703 Mitchell St. St. Joseph Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 27 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Agency Penn
18. (a) Signature of funeral director: W.A. Sullins
(b) Address: Gower Mo
19. (a) 10-28-47 (Date received local registrar) (b) G. E. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1947 hour 9 minute 30 A.M.
21. I hereby certify that I attended the deceased from 8-16-47, 19..., to Oct 25 1947, that I last saw her alive on Oct 25 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis — Duration: unknown
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: NPD
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? (Specify type of place)
While at work?
(e) Means of injury: 0

23. Signature: Maxwell Day (M. D. or other)
Address: 218 N 7th St. Date signed: 10-28-47

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

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. 1738

P. O. Address Grover 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.