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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 339

Primary Registration District No. 3073

Registrar's No. 1

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Chaffee  
(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 years, months or days)

In this community 25 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Chaffee  
(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 Mollie Angelina Watkins

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 1948 hour 7 minute 0 A.M.

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Sam Watkins 6. (c) Age of husband or wife if alive years

7. Birth date of deceased July 3 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 8 to July 15, 1948 that I last saw her or alive on July 15, 1948 and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 8 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death myocarditis

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

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

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

10. Usual occupation Housekeeper

Other conditions kidney condition with fluid in urine  
(Include pregnancy within 3 months of death)

Major findings: Of operations 93K

Of autopsy \_\_\_\_\_

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

12. Name Unknown

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

14. Maiden name Unknown

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Henry Eldredge

(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 1-6-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Park Chaffee Mo

18. (a) Signature of funeral director Bisplinghoff Funeral Home

(b) Address Chaffee Mo

19. (a) 1/9/48 (b) J B MacCreedy  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

23. Signature W W Davault (M. D. or other) MD  
Address Marionville Mo Date signed Jan 6/48

RECEIVED

District Health Office No. 2

District File Number 148-82

Date Filed 1-19-48

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.....

*Jack J. Burnett*....., Registered Apprentice No. *516*  
working under my personal supervision.

Signed *Mamie Dupling Hoff*.....

Licensed Embalmer No. *3242*.....

P. O. Address *Chaffee 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.