

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH5074  
STATE FILE NUMBERRegistration District No. 149 Primary Registration District No. 1002 Registrar's No. 440

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ARKANSAS</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>HARRISON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital 2 wtra</u> Length of stay in lb		d. STREET ADDRESS (If outside give location) <u>619 North Pine</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Ralph Watkins</u>			4. DATE OF DEATH Month Day Year <u>JAN 27 1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 3, 1893</u>
9. AGE (In years last birthday) <u>63</u>		10. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>HARRISON, ARKANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>William Watkins</u>	
14. MOTHER'S MAIDEN NAME <u>ETTA KAUFMAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS WATKINS HARRISON, ARKANSAS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction due to coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>13 January 57</u> to <u>27 Jan 1957</u> and last saw <sup>her</sup> him alive on <u>27 Jan 57</u> . Death occurred at <u>9:15 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Blaine Z. Hibbard MD</u>		22b. ADDRESS <u>411 Nichols Rd. KCMO</u>	
22c. DATE SIGNED <u>28 Jan 57</u>		23a. BURNED, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>JAN 29, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>—</u>	
23d. LOCATION (City, town, or county) <u>HARRISON, ARKANSAS</u>		(State)	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMBSONS 1331 K.C. Mo. BRUSH CREEK Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-57</u>	
26. REGISTRAR'S SIGNATURE <u>Blaine Z. Hibbard</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no stated. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Blaine Z. Hibbard

MEDICAL CERTIFICATION

**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 ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Basil V. Honey* .....

Licensed Embalmer No. *47* .....

P. O. Address *K.C., Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.