

Health,
& Welfare
Public
Service

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34939

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. _____ Registrar's No. 1091

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>722 Main</u>		d. STREET ADDRESS (If outside, give location) <u>722 Main</u>	
Length of stay in 1b <u>4 months</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>RONNIE</u> Middle <u>LEE</u> Last <u>WATKINS</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1957</u>	9. AGE (In years last birthday) <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Watkins</u>	13b. MOTHER'S MAIDEN NAME <u>Betty Ball</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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>none</u>	17. INFORMANT <u>Mrs. Robert Watkins</u>	Address <u>722 Main</u>
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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>dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>3-4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pneumonia</u>		
DUE TO (c) <u>liquid as an unattended death in the city of St. Joseph, Mo</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>St. Joseph, Mo</u>	COUNTY _____ STATE _____
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21. I attended the deceased from 10-9-57 to _____ and ^{never} ~~last~~ saw ^{her} ~~him~~ alive on _____
Death occurred at 6:05 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Richard A. Magrin M.D. assistant city health officer</u>	22b. ADDRESS <u>Phys - Drug Bldg 216, St. Joseph, Mo</u>	22c. DATE SIGNED <u>10-11-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>
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24. FUNERAL DIRECTOR <u>Phred Luff</u>	ADDRESS <u>6054 Pryor</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 14, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.