

# FEDERAL BUREAU OF INVESTIGATION

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**FILED VS MAR 8 1960**

2 2244 - 59-047115

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jefferson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>59 Min.</b>		c. CITY OR TOWN <b>Arnold</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda General Hosp.</b>				d. STREET ADDRESS (If outside, give location) <b>R.R. 2 Box 28D</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Lesley Ann Watkins</b>			4. DATE OF DEATH <b>12-23-59</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-59</b>		
				9. AGE (last birthday) <b>0</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours <b>59</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Newborn</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Leslie Burke Watkins</b>			13b. MOTHER'S MAIDEN NAME <b>Gloria Violet Romeo</b>			14. NAME OF HUSBAND OR WIFE <b>-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>R.R. Box 28D Gloria V. Watkins Arnold, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>achondroplasia</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>758.1</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? 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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>12-23-59</b> to <b>12-23-59</b> and last saw <sup>her</sup> him alive on <b>12-23-59</b> Death occurred at <b>12 5:32 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Guy Jones</i>			22b. ADDRESS <b>4500 Olive St. St. Louis, Mo.</b>			22c. DATE SIGNED <b>2-12-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>12/24/1959</b>		<b>Memorial Park</b>		<b>Cape Girardeau, Mo.</b>		
24. FUNERAL DIRECTOR <b>L. L. Haman-Cape Girardeau, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 26 1960</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mrl*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Body Was Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.