

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED **V8** SEP 7 1960

60-032429
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2407

NDED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester		Length of stay in 1b DAYS	c. CITY OR TOWN Webster Groves Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Crest Nursing Home		Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 621 Cornell Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LEWIS Middle ALLEN Last WATKINS	4. DATE OF DEATH Month August Day 8 Year 1960
---	---

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/2/90	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	--	-----------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) LaCrosse, Arkansas	12. CITIZEN OF WHAT COUNTRY U. S. A.
--	--	---	--

13a. FATHER'S NAME Ben Watkins	13b. MOTHER'S MAIDEN NAME Mandy ?	14. NAME OF HUSBAND OR WIFE _____
--	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-07-5855	17. INFORMANT Leora Brooks Address 416 Winstanley E. St. Louis, Ill.
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic-Cardio-Vascular Disease DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH _____
--	---

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"/> None	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 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 7-28-60 to 8-8-60 and last saw her/him alive on 8-4-60
Death occurred at 8-8-60 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Allen M. Kearney M.D.	22b. ADDRESS 4308 E. Peter St. Louis Mo	22c. DATE SIGNED 8-9-60
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (State official) Burial	23b. DATE 8/11/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-----------------------------	---	---

24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. Aug 12 1960	26. REGISTRAR'S SIGNATURE <i>John B. Murphy</i>
---	-------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

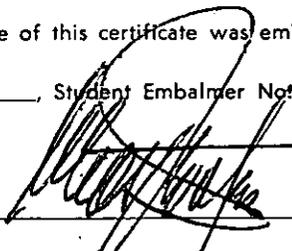
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____


Licensed Embalmer No. 1876

P. O. Address 4107 Finney

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