

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040138

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 720

FILED DEC 4 1961

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shelby</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>9 Weeks</u>		c. CITY OR TOWN <u>Clarence</u>		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>Boone County Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Knupp</u> Last <u>Watkins</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-1869</u>		9. AGE (last birthday) <u>91</u>		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) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Stiles, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Samuel Knupp</u>				13b. MOTHER'S MAIDEN NAME <u>Katherine Foshee</u>				14. NAME OF HUSBAND OR WIFE <u>James Sigler Watkins</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>None</u>		17. INFORMANT Address <u>Ralph K. Watkins 702 Ingleside Dr.</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>Cerebral Artery Occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized and cerebral arteriosclerosis</u>										is <u>Several</u> Years					
DUE TO (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of neck of right femur</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>Fall in home.</u>											
20c. TIME OF INJURY <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m. <u>9-28-61</u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Clarence</u>		COUNTY <u>Shelby</u>		STATE <u>Mo.</u>	
21. I attended the deceased from <u>9-28-61</u> to <u>11-30-61</u> and last saw her/him alive on <u>11-30-61</u> Death occurred at <u>5:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>[Signature]</u> Name or title <u>MD</u>						22b. ADDRESS <u>417 Guitar Bldg. Columbia Mo.</u>				22c. DATE SIGNED <u>11-30-61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11/30/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CLARENCE CEMETERY</u>			23d. LOCATION (City, town, or county) (State) <u>CLARENCE, MISSOURI</u>								
24. FUNERAL DIRECTOR <u>PARKER'S FUNERAL SERVICE</u>				ADDRESS <u>MO. COLUMBIA</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 30 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 4 1962

DEC 7 1961

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 Charles V. Sheen

Licensed Embalmer No. 4625

P.O. Address Clarence

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.