

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

NOV 13 1939
Registration District No. **1002**

Primary Registration District No. _____

1. PLACE OF DEATH: **1002**
(a) County **2**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **2912 Laclade**
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **1**
(c) City or town **St. Louis** **18**
(d) Street No. **2912 Laclade**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Foetus Watts**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **Col**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **9** day **24**
year **1939** hour **12** minute **P.** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

8. AGE: Years _____ Months **2** Days **4** If less than one day _____ hr. _____ min.
9. Birthplace **St. Louis, Mo.**
10. Usual occupation **nie**

that I last saw h _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death **Spontaneous Abortion**
Due to **Spontaneous Abortion**
Due to **Spontaneous Abortion**
Other conditions **Cause Unknown**

MOTHER FATHER
11. Industry or business _____
12. Name **Aggie Watts**
13. Birthplace **Miss**
14. Maiden name **Beatrice Ross**
15. Birthplace **Miss**

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Aggie Watts**
(b) Address **2912 Laclade**
17. (a) _____ (b) Date thereof **9-28-39**
(c) Place: burial or cremation **St. Louis**
18. (a) Signature of funeral director **W. Richter**
(b) Address **3820**
19. (a) **OCT 3 1939** (b) _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) _____
Means of injury _____
23. Signature **Aggie M. Watts** (M. D. or other) _____
Address **Deputy**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.