

S. No. 2
-11-10-39
5-17-39
PI X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16583

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **4061**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community Life years, months or days (Specify whether)

3. (a) PRINT FULL NAME Tessloing Watson **325**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 4 1932
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>7</u>	<u>8</u>	<u>28</u> hr. _____ min.

9. Birthplace St. Louis Mo U
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Mose Watson !

13. Birthplace Wt. Knover Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Christine Burgess

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Christine Watson

(b) Address 3037 Magazine

17. (a) _____ (b) Date thereof 5-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director J. H. Richardson

(b) Address 962 1/2 Glasgow

19. (a) MAY 6 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 3037 Magazine
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5th day 1st
year 10 hour 30 minute _____ M.

21. I hereby certify that I attended the deceased from 9/18, 1939, to 5/1, 1940
that I last saw him alive on 5/1/40
and that death occurred on the date and hour stated above.

Immediate cause of death Sickle cell anemia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Enlarged liver
Of operations Mediastinal adenopathy

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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)

(e) Means of injury _____

23. Signature Ralston S. Mitchell (M. D. or other) _____

Address 1536 Papen St Date signed 5/2/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

J. D. Richardson

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.