

4-13-40
5-17-39
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FILED JUN 25 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16392
State File No. _____
Registrar's No. **3910**

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether _____)
In this community **33 years**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **1718**
(d) Street No. **3226 Hickory**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **William Watkins**
(b) If veteran, name war **No**
(c) Social Security No. **4-97-10-1075**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **4**
year **1941** hour **12:00 Noon** minute _____ M.

4. Sex **MALE** 5. Color or race **Col**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **ANNIE**
6. (c) Age of husband or wife if alive **59** years
7. Birth date of deceased **2-1886**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 3,** 19**41**, to **May 4,** 19**41**;
that I last saw him alive on **May 4,** 19**41**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertension**
Duration **Indef.**

8. AGE: Years **55** Months **4** Days **2**
If less than one day hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

9. Birthplace **UNKNOWN TENN.**
(City, town, or county) (State or foreign country)
10. Usual occupation **LABORER**

MOTHER FATHER
11. Industry or business _____
12. Name **UNKNOWN**
13. Birthplace **" " "**
(City, town, or county) (State or foreign country)
14. Maiden name **" " "**
15. Birthplace **" " "**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Annie Watkins**
(b) Address **3226 Hickory**
17. (a) **BURIAL** (b) Date thereof **5-40-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood**
18. (a) Signature of funeral director **Benjamin**
(b) Address **3103 Washington**
19. (a) **MAY 8 1941** (b) **J. T. Breda**
(Date received local registrar) (Registrar's signature)

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)
(M. D. or other) _____
23. Signature **Edith W. Whittier** (M. D. or other) _____
Address **2601 N. Whittier** Date signed **4-5-41**

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.....

W. Edwin Bleckman

Licensed Embalmer No.....

3962

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, fact should be so stated above.