

No. 2
1-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30514**
Registrar's No. **8382**

FILED OCT 2 - 1943 318
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Majestic Hotel
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 2 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ralph Watts

3. (b) If veteran, name war R. B. A. Team

(c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Verona Curtis Watts

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Apr 24 1886
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace England
(City, town, or county) (State or foreign country)

10. Usual occupation Registrar

11. Industry or business Plastics Institute

12. Name Leaac Watts

13. Birthplace England
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Sullivan

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

16. (a) Informant Mrs. Verona Curtis Watts

(b) Address 802 Monroe St. Cranston, Ill.

17. (a) Cremation (b) Date thereof 9 21 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri

18. (a) Signature of funeral director Wagoner

(b) Address 3621 Olive St.

19. (a) SEP 21 1943 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cook

(c) City or town Cranston
(If inside city or town limits, write "RURAL")

(d) Street No. 802 Monroe St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1943 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Coronary Sclerosis

Due to _____

Due to 94

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

Major findings: Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature Alfred J. Perry M. D. or other _____

Address Chicago, Ill. Date signed 9/21/43

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 *Neville B. Frohwitter*

Licensed Embalmer No. *3696*

P. O. Address *3621 Olive Rd.*

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.