

FILED SEP 28 1945

Registration District No.

Primary Registration District No.

1003

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:
3101 Thomas St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 12 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aco
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3101 Thomas St. (If rural, give location)
(e) Citizen of foreign country? d (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Watson

3. (b) If veteran, name war _____

3. (c) Social Security No. 408-10-7527

4. Sex Male 5. Color or race Col.

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

6. (b) Name of husband or wife Lillie Watson

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased March 4 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 6 2 hr. min.

9. Birthplace Lexington Miss. /
(City, town, or county) (State or foreign country)

10. Usual occupation Skilled Laborer

11. Industry or business _____

12. Name George Watson

13. Birthplace Unknown Miss. /
(City, town, or county) (State or foreign country)

14. Maiden name Cornelious Davenport

15. Birthplace unknown Miss. /
(City, town, or county) (State or foreign country)

16. (a) Informant Lillie Watson

(b) Address 3101 Thomas St.

17. (a) Burial (b) Date thereof 9-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washinton Park

(a) Signature of funeral director Ellis Fun. Home

(b) Address 2820 Stoddard St.

19. (a) SEP 12 1945 (b) [Signature]
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6th year 1945 hour _____ minute 30 M.

21. I hereby certify that I attended the deceased from Sept 6th 1945 to Sept 6th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Failure
Chr. Myocarditis
Hypertensive Heart Disease
Duration: 2 wks
6 months
1 year

Other conditions (Include pregnancy within 3 months of death) 93

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) (e) Means of injury _____

23. Signature: [Signature] (M. D. or other) _____
Address: 28350 Calumet Ave Date signed: 9-7-45

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

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17
9

FEB 17 1958

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 L. Bayne

Registered Apprentice No. _____

working under my personal supervision.

Signed Tommy Bayne

Licensed Embalmer No. 2947

P. O. Address St. Louis, Mo.

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.