

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 5544

FILED JUL 31 1946  
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County ~~XXXXXX~~  
(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 Phillip Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 20 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")  
(d) Street No. 3961 Fairfax  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John W. Watson  
3. (b) If veteran, name war 70  
3. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 17  
year 1946 hour 4 minute 30 M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col.  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bettie Watson  
6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) 1890 (Year)

Immediate cause of death \_\_\_\_\_  
Due to Crown Aneurism  
Due to Crown Aneurism  
Other conditions (Include pregnancy within 3 months of death) 94  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation See Saluman

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Morris Watson

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

14. Maiden name Lizzie (?)

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

16. (a) Informant Retha Watson

(b) Address 8961# 3961 Fairfax

17. (a) Removal (b) Date thereof 6/24/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. Place: burial or cremation E. Adams St

18. Signature of funeral director J. F. Brebeck

(b) Address 3517 St. Louis, Missouri

19. (a) JULIAN 22 1946 (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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature John W. Watson (M. D. or other)  
Address 3961 Fairfax St. St. Louis Date signed 6/19/46

**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.....

*Melvin Edward Green*, Registered Apprentice No. *383*,  
working under my personal supervision.

Signed *M. E. Green*.....

Licensed Embalmer No. *1173*.....

P. O. Address *3517 Sackville ave*.....

**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.**