

No. 2
9-4-41
-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3216**
964
Registrar's No. _____

FILED FEB 9 1948

Registration District No. **318**

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:
St. Louis Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 hours - 20 min.
(Specify whether
In this community yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
Missouri
(a) State _____ (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1433 Cass
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT Beverly Ann Watkins
FULL NAME

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased January 10, 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hr. 20 min.

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

10. Usual occupation Infant

11. Industry or business Restaurant

12. Name Joseph H. Watkins

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

14. Maiden name Hortense Williams

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mother

(b) Address 1433 Cass St. Louis

17. (a) Anatomical Board (b) Date thereof JAN 31 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director H. F. Rowland

(b) Address 406 Washington

19. (a) JAN 31 1948 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11
year 1948 hour 6:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from 1-10-48
_____, 19____, to 1-11-48, 19____

that I last saw her alive on 1-11-48, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Subarachnoid Hemorrhage over left nucleus & around brain stem Duration 12 hrs.

Due to Contracted pelvis, long labor & difficult delivery

Due to _____

Other conditions none
(Include pregnancy within 5 months of death)

Major findings: Of operations _____

Of autopsy Subarachnoid hemorrhage over left nucleus & brain stem

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 Robert J. Youngman (M. D. or other) MD

Address St Louis Maternity Hospital Date signed 1-11-48

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

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.