

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

FILED NOV 12 1948  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9395

1. PLACE OF DEATH:  
(a) County: St. Louis Mo.  
(b) City or town: St. Louis Mo.  
(c) Name of hospital or institution: St. Mary's Hospital  
(d) Length of stay: In hospital or institution (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo.  
(b) City or town: St. Louis Mo.  
(c) Street No.: 221 S. 5th St.  
(d) Citizen of foreign country? (Yes or No)

In this community years, months or days

3. (a) PRINT FULL NAME: Joseph Watcull  
3. (b) If veteran, name was  
3. (c) Social Security No.

4. Sex: Male  
5. Color: White  
6. (a) Single, widowed, married, divorced, wid.   
6. (b) Name of husband or wife.  
6. (c) Age of husband or wife at death: 41 1/2 years  
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

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

10. Usual occupation: work

11. Industry or business: work

12. Name: work

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

14. Maiden name: work

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

16. (a) Informant: Anatomical Board  
(b) Address: 300 S. 5th St.

17. (a) (Burial, cremation, or removal) Anatomical Board  
(b) Date thereof: OCT 31 1948  
(c) Place: burial or cremation

18. (a) Signature of funeral director: Rowland Mortuary Service  
(b) Address: 4104 Manchester Ave.

19. (a) OCT 31 1948 (Date received local Registrar)  
(b) J. B. Easter (Registrar's signature)

20. DATE OF DEATH: Month OCT day 17 year 1948 hour 1:30 min. M.  
21. I hereby certify that I attended the deceased from 1948 to 1948 that I last saw him alive on 1948 and that death occurred on the date and hour stated above.  
Immediate cause of death: CHRONIC HYPERTROPIC MYOCARDITIS. CORONARY OCCLUSION.

Other conditions: (Include pregnancy within 3 months of death)  
Major findings: 1/3 Dr. M.A.  
Of operations:  
Of autopsy:  
PHYSICIAN: Underline the cause of 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, or while at work? (Specify type of place) Means of injury: 5.  
Signed: Charles E. Taylor

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 Ralph W. Hemen  
Licensed Embalmer No. 3791  
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.

Registration District No. 314 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: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Joseph Walcott  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: 47 Years 66 Months 18 Days (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) J. B. Pasater (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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

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