No. 300
10.48

FILED APR 21 1949

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 14264
3280

BIRTH NO. _____ REG. DIST. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Firmin Desloge Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo.
d. STREET ADDRESS (If rural, give location) 5319a Easton Avenue

3. NAME OF DECEASED (Type or Print) a. (First) Bird b. (Middle) c. (Last) Watson
4. DATE OF DEATH (Month) (Day) (Year) 4-10-49
5. SEX Male
6. COLOR OR RACE Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 7-18-78
9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harrisburg, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Files Watson
13b. MOTHER'S MAIDEN NAME Julie Pemberton
14. NAME OF HUSBAND OR WIFE Lula Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Lula Brown ADDRESS 5319a Easton Ave.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 12 hr.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive Cardiovascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.* Chronic asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 443 X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-12-49 *19*____, *to* 4-10-49, *19*____, *that I last saw the deceased alive on* 4-10-49 *19*____ *and that death occurred at* 2:10 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE John J. Inkley, M.D. (Degree or title)
23b. ADDRESS 1325 S. Grand, St. Louis, Mo.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-13-49
24c. NAME OF CEMETERY OR CREMATORY Walhalla Cem.
24d. LOCATION (City, town, or county) St. Louis County (State) Mo.

DATE REC'D BY LOCAL REG. APR 12 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Sullivan ADDRESS 1229 Lawton Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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

## 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 ..... Student Embalmer No. ....., working under my personal supervision.

Student ..... Student Embalmer

Signed Clement McNear

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.