

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32306

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8048**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place) township) 16 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	d. STREET ADDRESS (If rural, give location) 220 North Park Plaza hotel Kingshighway
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, (1)			

3. NAME OF DECEASED (Type or Print) a. (First) Rffalyn	b. (Middle) Lulu	c. (Last) Watkins	4. DATE OF DEATH (Month) (Day) (Year) Sept. 15 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Edina	12. CITIZEN OF WHAT COUNTRY? Missouri
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13a. FATHER'S NAME Marsh	13b. MOTHER'S MAIDEN NAME Lessie C. Caldwell	14. NAME OF HUSBAND OR WIFE T. D. Watkins
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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 Helen P. Wargand	ADDRESS E. St. Louis
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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) Chronic hepatitis and cholangitis		INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: Renal failure. Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 124 5810
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug. 30** 19 **49** to **Sept. 15** 19 **49**, that I last saw the deceased alive on **Sept. 15** 19 **49**, and that death occurred at **11:55 P.**, from the causes and on the date stated above.

23a. SIGNATURE Lawrence W. O'Neil M.D.	23b. ADDRESS Barnes Hospital,	23c. DATE SIGNED 9/16/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-19-49	24c. NAME OF CEMETERY OR CREMATORY Sunset Hill	24d. LOCATION (City, town, or county) (State) Edwardsville, Ill.
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DATE REC'D BY LOCAL REG. SEP 17 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS [Address]
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 19 1949

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 _____

Licensed Embalmer No. 3162

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.