

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28775

State File No.

FILED SEP 15 1950

318

REG. DIST. NO. PRIMARY REG. DIST. NO.

1003

Registrar's No. 71227

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute Homer G. Phillips Hosp.		d. STREET ADDRESS (If rural, give location) 513 So. Ewing Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Huddie b. (Middle) c. (Last) Watson			4. DATE OF DEATH (Month) (Day) (Year) 8-19-1950
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 17, 1920
9. AGE (In years last birthday) 30		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Point Miss.
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Love Watson	
13b. MOTHER'S MAIDEN NAME Addie B. Pittman		14. NAME OF HUSBAND OR WIFE Lillie Mae Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO. 425-26-5997	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillie Mae Watson 513 So. Ewing Ave.
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.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Neurogenic Heart Diarrhea			
DUE TO (b)			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS 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"/>			
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H202	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. B. Jones, M.D., Coroner		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 8/21/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/25/50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) West Point Mississippi
DATE REC'D BY LOCAL REG. AUG 22 1950	REGISTRAR'S SIGNATURE J. B. Kessler	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home Inc. 2820 Stoddard St	

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

1366
3

SEP 20 1950

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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address Shelton 13. 2nd

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.