

FILED SEP 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31935

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8237

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4655 TESSON ST.		d. STREET ADDRESS (If rural, give location) 4655 TESSON ST. 0	

3. NAME OF DECEASED (Type or Print) a. (First) MARY	b. (Middle) AGNES	c. (Last) WATSON	4. DATE OF DEATH (Month) (Day) (Year) SEPT-15-51
5. SEX FE 1	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH JUNE-10-1875 76 YRS.
9. AGE (In years last birthday) 76 YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	11. BIRTHPLACE (State or foreign country) MO 0
12. CITIZEN OF WHAT COUNTRY U.S.A.			

13a. FATHER'S NAME Patrick Hobbs	13b. MOTHER'S MAIDEN NAME MARY MOTIN	14. NAME OF HUSBAND OR WIFE Alex Watson
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 Mrs Margaret Nicholson
		ADDRESS 4655 Tesson St

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 M O
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) THROMBOSIS - LENTICULOSTRIAL ARTERY		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) CYCLAR DISEASE		
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 type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HIT BY CAR
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22. I hereby certify that I attended the deceased from Sept 14, 1951, to SEP 15, 1951, that I last saw the deceased alive on SEP 15, 1951, and that death occurred at 6:01 m., from the causes and on the date stated above.

23a. SIGNATURE Herbert C. Sweet	(Degree or title) M.D.	23b. ADDRESS 506 N. GRAND ST. LOUIS, MO	23c. DATE SIGNED 9-17-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Sept 18-51	24c. NAME OF CEMETERY OR CREMATORY CALVARY Cem.	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL SEP 17 1951	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schurer	ADDRESS 3125 Lafayette St
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1001

W. J. Jones of
St. Paul, Minn. received
3-5-1917

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 Joseph Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.