

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14893**
Registrar's No. **3660**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
		d. STREET ADDRESS (If rural, give location) 26 1502 Blair St	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Lula			b. (Middle) Watkins		
c. (Last)			April 16 1952		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 1, 1870	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR: Days 0 Hours 15 Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Memphis, Tenn.	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME William Brown		13b. MOTHER'S MAIDEN NAME Lula Warren		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph Watkins 1502 Blair Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		DUE TO (b) Undetermined			Undet.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Old Cerebral Hemorrhage			Undet.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Cellulitis of Face			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X			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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR		

22. I hereby certify that I attended the deceased from **4-8, 1952**, to **4-16, 1952**, that I last saw the deceased alive on **4-16, 1952**, and that death occurred at **3 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm A Reid M.D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-16-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Apr. 21, 1952		24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	

DATE REC'D BY LOCAL REG. APR 18 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave.	
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mjs (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 _____

Licensed Embalmer No. 249 A

P. O. Address 2469 1/2 hant

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.