

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

State File No. **10510**
Registrar's No. **2520**

FILED MAR 30 1954
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If rural, give location) 2503 Bacon St.	
3. NAME OF DECEASED (Type or Print) a. (First) Wallace b. (Middle) _____ c. (Last) Watts		4. DATE OF DEATH (Month) (Day) (Year) 3 14 54	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 27th 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Catholic Church	9. AGE (In years last birthday) 57 # UNDER 1 YEAR Months _____ # UNDER 24 HRS. Days _____ Hours _____ Min. _____
11a. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME Georgia Mae Watts?	
14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. KW 1	
17. INFORMANT'S SIGNATURE OR NAME Lucille Ewing		ADDRESS 2503 Bacon	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver	
		ANTECEDENT CAUSES Lobar pneumonia Rt.	
		DUE TO (b) Hypertension (Hypertension)	
		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 type="checkbox"/> NO <input checked="" type="checkbox"/>		190X	
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 <u>Mar 1, 1954</u>, to <u>Mar 14, 1954</u>, that I last saw the deceased alive on <u>March 14, 1954</u>, and that death occurred at <u>8 a.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <i>Walter A. Young</i>		23b. ADDRESS 2337 Market Street	
23c. DATE SIGNED 3-16-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-22-54	
24c. NAME OF CEMETERY OR CREMATORY National		24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri	
DATE REC'D BY LOCAL REG. MAR 19 1954		REGISTRAR'S SIGNATURE <i>Carl Smith</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Ellis Funeral Home, 2820 Stoddard Street	

(Licensed Embalmer's Statement on Reverse Side)

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 Julius E. Cappel

Licensed Embalmer No. 4198

P. O. Address Albany 3

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.