

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

36103

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8632

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>	c. LENGTH OF STAY (in this place) <u>1 DAY</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HOMER PHILLIPS HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>21 3224 LAWTON</u>	

3. NAME OF DECEASED (Type or Print) <u>ALPHONSO WATTS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 18 54</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 10, 1890</u>		9. AGE (In years last birthday) <u>64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>CANNON, MISS</u>	
13a. FATHER'S NAME <u>SY WATTS</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MARY COLLINS</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WARI 7-14-1919 NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MARY WATTS</u> ADDRESS <u>3224 Lawton</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Hydrothorax</u>			INTERVAL BETWEEN ONSET AND DEATH
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardiac Hypertrophy</u>			

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)
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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? <u>4342</u>
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22. I hereby certify that I attended the deceased from _____, 1954, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Patrick P. Taylor Carver</u>	23b. ADDRESS <u>1300 Clark</u>	23c. DATE SIGNED <u>9.21.54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>9-24-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>JEFF. BARRACK, Mo</u>
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DATE REC'D BY LOCAL REG. <u>SEP 22 1954</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>McCLAIN FUNERAL HOME</u> ADDRESS <u>1300 Clark, Jefferson, Mo</u>
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OCT 26 1935

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 *Leroy H. Sammito*

Licensed Embalmer No. *4523*

P. O. Address *3880 Easto*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.