

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11634

State File No.

318

1003

Registrar's No. 2387

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3406² LASALLE, ST.</u>				e. STREET ADDRESS (If rural, give location) <u>3406² LASALLE</u> <u>18</u> <u>21870</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>ROSETTA</u>		(Middle) _____		(Last) <u>WILLS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>3</u> <u>1956</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG 7 1891</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hour _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>COVINGTON TENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Smith</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE WYNN</u>		14. NAME OF HUSBAND OR WIFE <u>NOBLE WILLS SR.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Noble Will JR. 3406² LASALLE ST.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Cerebral Apoplexy</u>		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>334X</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR _____			
22. I hereby certify that I attended the deceased from <u>9/19</u> , 19 <u>55</u> , to <u>3/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>D. E. Watson M.D.</u> (Degree or title)				23b. ADDRESS <u>3106 Chestnut</u>		23c. DATE SIGNED <u>3/5</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>3-9-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County MO</u>	
DATE REC'D BY LOCAL REG. <u>MAR 7 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. J. WATSON 2769 Chouteau</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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.....
Signature of Student Embalmer

Signed.....
J. J. Watson

Licensed Embalmer No. *26*

P. O. Address *2769*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.