

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11256

STATE FILE NUMBER

FILED APR 12 1957

Registration District No. _____

318

Primary Registration District No. _____

1003

Registration No. 2551

Health,
Welfare
Public
Services

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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; give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEACONESS-HOSP.</u>		Length of stay in 1b <u>28 HAS 9</u>		d. STREET ADDRESS <u>1601 Sulphur</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES A WATTERS</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-1885</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MULLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK & CLAY</u>		11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH-WATTERS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN KYLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-01-5632</u>		17. INFORMANT Address <u>RUTH-WATTERS-1601 Sulphur</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobar Pneumonia</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Diplococcus Pneumoniae</u>	
						DUE TO (c) <u>490x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>Old & Recent Coronary Thromboses</u>						<u>2 weeks</u>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>11-mch</u> to <u>19-mch</u> and last saw <u>him</u> alive on <u>mch-12-57</u> . Death occurred at <u>1:10 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. Miller M.D.</u>				22b. ADDRESS <u>4501 e Manhattan</u>		22c. DATE SIGNED <u>mch-14-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3-15-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCHYARD</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>JAY-B-SMITH-FUNERAL HOME</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 15 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

S.P.

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. Allen Davis*
Licensed Embalmer No. *40*
P. O. Address *St. L.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.