

FILED DEC 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42761
State File No. 11795

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>11795</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>					
b. CITY OR TOWN <u>ST Louis, Missouri</u>		c. LENGTH OF STAY (in this place) <u>2 DAY</u>		c. CITY OR TOWN <u>ELS BERRY</u>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CHILDREN'S HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>31 412 S. THIRD STREET</u> 257c					
3. NAME OF DECEASED (Type or Print) a. (First) <u>DONNIE</u>		b. (Middle) <u>Gene</u>		c. (Last) <u>WATTS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 - 6 - 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>December 5, 1957</u>			
9. AGE (In years last birthday) <u>7 DAY</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>LOUISIANA, MISSOURI</u>			
11. BIRTHPLACE (City and State or Foreign Country) <u>LOUISIANA, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Kenneth Woodrow Watts</u>		13b. MOTHER'S MAIDEN NAME <u>Adaline Culwell</u>			
14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jane Henrichsen - 500 S. Kingshighway</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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Congenital heart disease & congestive failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12-5-57 to 12-6-57</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>754.4</u>				19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY? YES <input checked="" 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 type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>12-5</u> , 1957, to <u>12-6</u> , 1957, that I last saw the deceased alive on <u>12-6</u> , 1957, and that death occurred at <u>3⁴⁵ P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____				23b. ADDRESS <u>500 S. Kingshighway</u>		23c. DATE SIGNED <u>12-6-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>DEC 9 57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Elsberry Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Elsberry Mo.</u>			
DATE REC'D BY LOCAL REG. <u>DEC 9 57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clifton C. Miller Elsberry Mo.</u>					

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.....
Signature of Student Embalmer

Signed *Clarence M. Bullo*.....

Licensed Embalmer No. *4375*
P. O. Address *St. Charles Mo.*.....

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.