

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046479

STATE FILE NUMBER

97512-58
FILED JAN 14 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 12800

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1-57

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|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN ST. LOUIS, MO. |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. | | Length of stay in lb #2/9 | d. STREET ADDRESS (If outside, give location) 1347 NO. GARRISON |
| Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |

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|--|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last (BABY BOY) WATSON | | | 4. DATE OF DEATH Month Day Year 12 -25 - 1958 | | |
| 5. SEX MALE 2 | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/25/58 | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min 5 |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME JOHN WATSON | 13b. MOTHER'S MAIDEN NAME CARRIE NUNN | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If no give war or dates of service) no | 16. SOCIAL SECURITY NO. NO | 17. INFORMANT ST. LOUIS CITY HOSP. #1. Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain trauma. | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Cephalopelvic Disproportion | |
| | DUE TO (c) Hydrocephalus. 752x | |
| 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 type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 Month, Day, Year 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 **12-25-1958**, to **12-25-1958** and last saw her alive on **12-25-1958**
Death occurred at **12:35 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22. SIGNATURE (Degree or title) Arthur A. Smith, M.D. | 22b. ADDRESS 1515 LAFAYETTE AVE. | 22c. DATE SIGNED 12-25-1958 |
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|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 1-31-59 | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| 24. FUNERAL DIRECTOR Rowland Aker 4104 Manchester | 25. DATE REGD. BY LOCAL REG. JAN 8 59 | 26. REGISTRAR'S SIGNATURE Carl Smith MD |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

Signed

Signature of Student Embalmer

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Licensed Embalmer No.

P. O. Address

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.