

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046566

STATE FILE NUMBER

FILED DEC 19 1958

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 30697

300  
-57

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside city or town, give county) OR TOWN <u>St. Louis Co., Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>Christian Old Peoples Home, 6600 Washington</u>		d. STREET ADDRESS (If outside, give location) <u>2841 Osceola Ave.</u>	
Length of stay in th <u>6 Yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>WATSON</u> Last <u>WATSON</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1958</u>		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1863</u>	9. AGE (In years last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
----------------------	-------------------------------	---	--------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Madison, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>James Black</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lichlyter</u>	14. NAME OF HUSBAND OR WIFE <u>Late Albert Watson</u>
---------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Bertha Ogden 2841 Osceola Ave.</u>
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	<u>20 years</u>
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	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>March 1957</u> to <u>Nov. 1958</u> and last saw him alive on <u>November 23, 1958</u> Death occurred at <u>9:15 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <u>Robert M. Louch, M.D.</u>	22b. ADDRESS <u>4952 Maryland Ave</u>	22c. DATE SIGNED <u>24 Nov. 58</u>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 25, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
---	--------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S.Kingshighway</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 24 '58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Plouffe, MD</u>
--	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

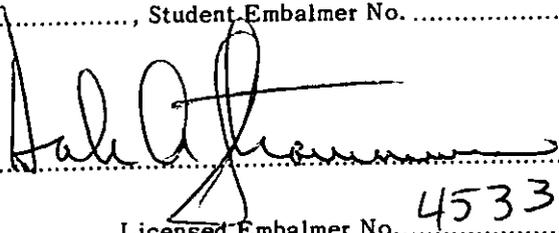
MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed  .....,  
Licensed Embalmer No. 4533

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.