

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003616  
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar **2** **897**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis.</b>	
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 <b>Enroute City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2202 1/2 P. 2020a Pestalozzi, St.</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Watson</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1911</b>
9. AGE (In years last birthday) <b>47</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baler Gaylord Mfg. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Holcomb, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James Watson</b>	
13b. MOTHER'S MAIDEN NAME <b>Lulu Wright</b>		14. NAME OF HUSBAND OR WIFE <b>Marie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>499-32-7240</b>	17. INFORMANT <b>Marie Watson, 2000a Pestalozzi, St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>420.1</b>			
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"/>
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 <b>11-30-57</b> , to <b>1-25-59</b> and last saw <sup>her</sup> him alive on <b>1-14-59</b> Death occurred at <b>2:10 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>O. Jones M.D.</b> (Degree or title)	22b. ADDRESS <b>3616 S. Broadway, St. Louis, Mo.</b>	22c. DATE SIGNED <b>1-26-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 26 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b> <b>mjb.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NS  
MAR 29 1960

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

MS AFIL 1 Signed Stanley H. Snow

Licensed Embalmer No. 4193

P. O. Address A. 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.