

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007763

STATE FILE NUMBER
2-2032

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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-57

28
94

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missour</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR ● TOWN <u>Saint Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Saint Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hosp. 5 hours</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>3867 Lincoln Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|------------------------------------|--|---|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella Mae Watson</u> | | | 4. DATE OF DEATH Month Day Year <u>2 - 24 - 1959</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Sep!</u> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11 - 23 - 1920</u> | 9. AGE (In years last birthday) <u>38 yrs.</u> | IF UNDER 1 YEAR Month Days <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Memphis, Tennessee</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |

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| 13a. FATHER'S NAME <u>Sylvester Johnson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lillie Smith</u> | | 14. NAME OF HUSBAND OR WIFE <u>Hubert L. Watson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>410-32-7209</u> | | 17. INFORMANT Address <u>Mrs. Lillie Cox - 3867 Lincoln Avenue</u> | |

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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) <u>ACUTE-EXSANGUINATION</u> <u>(DUE-TO-NOSE-BLEED-FROM-NASAL-ULCER-</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>517X (Non-Traumatic)</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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"/> |

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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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Regina M. [Signature]</u> | 22b. ADDRESS <u>1200 [Address]</u> | 22c. DATE SIGNED <u>2/26/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>3 - 2 - 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Saint Louis County, Missouri</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Gus Lowe - 2930 Dickson Street</u> | 25. DATE RECD. BY LOCAL REG. <u>FEB 26 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy U. Bannister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.