

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027466
STATE FILE NUMBER

318 1003 6565
Primary Registration District No. Registrar's No.

AMENDED
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

REGISTERED JUL 26 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Homer G. Phillips** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY
c. CITY OR TOWN **St. Louis** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **4431 Greer** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Henry** Middle **M.** Last **Watson** 4. DATE OF DEATH Month **7** Day **13** Year **61**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **5/28/88** 9. AGE (last birthday) **73** IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Mechanic** 10b. KIND OF BUSINESS OR INDUSTRY **Pullman Shops** 11. BIRTHPLACE (City and state or country) **McIntosh, La.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Samuel Watson** 13b. MOTHER'S MAIDEN NAME **Roxie Johnson** 14. NAME OF HUSBAND OR WIFE **Mary Watson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no** 17. INFORMANT **Mary Watson, 4431 Greer** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Carcinoma (Papillary) Thyroid with Metastasis** INTERVAL BETWEEN ONSET AND DEATH **Undet.**
DUE TO (b) _____
DUE TO (c) _____ **194x**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **6-16-61** to **7-13-61** and last saw her/him alive on **7-13-61**
Death occurred at **7:19 a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Sydney A. Masse** 22b. ADDRESS **2601 N. Whittier** 22c. DATE SIGNED **7-13-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **7/18/61** 23c. NAME OF CEMETERY OR CREMATORY **Washington Park** 23d. LOCATION (City, town, or county) (State) **St. Louis Co., Mo.**

24. FUNERAL DIRECTOR **Charles J. Gates, 4107 Finney** ADDRESS 25. DATE RECD. BY LOCAL REG. **JUL 14 1961** 26. REGISTRAR'S SIGNATURE **Good Smith M.D.**

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 *Geoffrey Swann*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.