LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

37627

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 11033

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Jennie Watson

(a) Residence. No. 2727 Bernard St., 7 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Negro	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~ Almedia Watson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28, 1883

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	8	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Magnolia
(STATE OR COUNTRY) Ark.

PARENTS

10. NAME OF FATHER Neal Watson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Magnolia
(STATE OR COUNTRY) Ark.

12. MAIDEN NAME OF MOTHER Sallie Bradford

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Magnolia
(STATE OR COUNTRY) Ark.

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED DEC -6 1923 Mary C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 3, 1923

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923, to Dec. 3, 1923 that I last saw him alive on Dec. 3, 1923, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Appendicitis 117
120B
129 (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) General Peritonitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....

D DID AN OPERATION PRECEDE DEATH? No. DATE OF.....
WAS THERE AN AUTOPSY? Yes - 12-3-23
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) S. K. Owen, M. D
, 19 (Address) City Hospital No. 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Magnolia Ark. DATE OF BURIAL 12/7 1923

20. UNDERTAKER Peoples Undertaking Co. ADDRESS 3100 Franklin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.