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

Do not use this space.

2583

791

1003

File No. .....

Registered No. 123

1. PLACE OF DEATH

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

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

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

17688

2. FULL NAME Donna Watts

(a) Residence. No. 3127 S. Jefferson St., 24 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 11 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22 1879

7. AGE: Years 47 | Months 5 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 46 E 46 G
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Felix Turner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Emma Barnes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED JAN 4 1927, 19 May C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Jan 2, 1927, that I last saw her alive on Jan 2, 1927, and that death occurred, on the date stated above, at 3:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of Gallbladder with metastases to omentum Operated 12/31 - Exploration of abdomen (duration) ..... yrs. ..... mos. ..... ds.

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

44 B

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? McClurg Laboratory

(Signed) W. J. Roche M.D.

1/3, 1927 (Address) City Hospital

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Elsberry Mo | DATE OF BURIAL: 1/5 1926

20. UNDERTAKER: W. A. Stock Med Co | ADDRESS: 7117 E. Grand

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.

Watts

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 123

City St. Louis (No. ..... St. ..... Ward)

2. FULL NAME Dorina Watts

(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 F | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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 1/11, 19..... Mae C Starcoff
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 1-5-1927

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

...y item of information sho... ...ld be stated EXACTLY. ...ANS sho... ...be properly class... ...Exact statement of OCCU... ...is very in...
...DEATH in plain terms, s...

...RARS SHALL NOT RECEIVE A F... ...OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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