

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

Do not use this space.

34029

1. PLACE OF DEATH

County St. Louis Co.
Township Central Pine Lawn
City Rolla (No. 7004 Oakwood Ave.)

Registration District No. 789
Primary Registration District No. 6033B

File No. _____
Registered No. 297 St. _____ Ward _____

2. FULL NAME

Mrs James H. Watson (Alice)
(a) Residence. No. 4004 Oakwood 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 18 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr James H. Watson

17. I HEREBY CERTIFY, That I attended deceased from 9-14, 1929 to 10-18, 1930 that I last saw him alive on 10-18, 1930 and that death occurred, on the date stated above, at 10:05 P.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 1859

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 71 3 19

Cr. cholesterolemia - Cr. cholecystitis
Emphysema of both lungs - 10 months
Cr. interstitial neph. arterial sclerosis
Cr. myocarditis (duration) ? yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Generalized jaundice, anemia
Chronic venous stasis (duration) yrs. mos. ds. 18
arterio-sclerotic atheros.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Home wife 59
(b) General nature of industry, business, or establishment in which employed (or employer). at home 131
(c) Name of employer 17

18. WHERE WAS DISEASE CONTRACTED ?

9. BIRTHPLACE (CITY OR TOWN) Fitz Madison
(STATE OR COUNTRY) Iowa

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

10. NAME OF FATHER Daniel F. Miller

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) Julius B. Timmer M. D.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Rebecca Phillips

(Address) 3118 Jennings St

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

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.

14. INFORMANT Mr. D. F. Miller Watson
(Address) 4004 Oakwood Ave.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 10-21 1930

15. FILED 10/20 1930 Rolla Tracy M. D. REGISTRAR

20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5766 Easton

Exact statement of OCCUPATION is very important.

NOV 28 1930

**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 St. Louis
Township Central
City..... (No.....)..... St. Ward)

Registration District No. 789
Primary Registration District No. 6.0 3 B
Registered No.

File No.
Registered No.
St. Ward)

2. FULL NAME

Mrs James H. Watson (Alice)

(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

MEDICAL CERTIFICATE OF DEATH

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)

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 10/30 1930 Allen Bracy M.D.
20 REGISTRAR

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

Oct 18 1930

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Cholelithiasis Cr.
Cholecystitis - Emphysematous
Gall Bladder - Cr. Intestinal
Peritonitis - Virus scleros
Cr. myocarditis
CONTRIBUTORY Generalized jaundice
(SECONDARY) Narcosis, acidosis (Diabetic)
(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.
, IS (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECORD OF DEATH IN plain territory that it is to be used. Registrar statement. For CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-34029