

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

Do not use this space.

37274

1. PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033B
 City St. Louis (No. 4004 Oakwood) St. _____ Ward _____

File No. _____

Registered No. 313

2. FULL NAME James Watson

(a) Residence. No. 4004 Oakwood Ave. 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Alice M Watson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb 21, 1852</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>7</u>
	DAYS <u>13</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Railroad C. Clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>retired</u> (c) Name of employer _____		

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

PARENTS	10. NAME OF FATHER <u>Don't know</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Don't know</u>
	12. MAIDEN NAME OF MOTHER <u>Sarah Donnelly</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Maryland</u>

14. INFORMANT Mrs. Leslie J. J. J. J. (Address) 404 Oakwood Ave

15. FILED 11/5 1930 Rolla Tracy M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 4 1930

17. I HEREBY CERTIFY, That I attended deceased from August 21, 1925 to November 4, 1930 that I last saw him alive on November 4, 1930 and that death occurred, on the date stated above, at 9:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Int. Nephritis, -Arterio Sclerosis
Chr. Hypertension.

18. WHERE WAS DISEASE CONTRACTED appendages. -Uremia.
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Luke B. Tiersohn M. D.
11/4, 1930 (Address) 3718 Jennings Rd.

*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 <u>Calvary Cemetery</u>	DATE OF BURIAL <u>11-6 1930</u>
20. UNDERTAKER <u>Geo. L. Pleitsch</u>	ADDRESS <u>5966 Eastern Ave.</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

DEC 3 1930

