

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.

JAN 12 1940

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

41631

10754

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County 1003
(b) City or town St. Louis MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolation Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 Days.
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Ada Watts 320

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Chas Nelson 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased August 15th 1899
(Month) (Day) (Year)

8. AGE: Years 40 Months 30 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Miss. (City, town, or county) (State or foreign country)

10. Usual occupation Maid. Private Family

11. Industry or business 9

MOTHER FATHER
12. Name Spencer Watt.
13. Birthplace Mississippi.
14. Maiden name Lulu Hinds
15. Birthplace Mississippi.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Stella Grady.
(b) Address 5600 Arsenal St.

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof Dec 18/39
(Month) (Day) (Year)
(c) Place: burial or cremation Walden Park

18. (a) Signature of funeral director F. W. Green
(b) Address 2915 Franklin Ave.

19. (a) DEC 17 1939 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri.
(a) State _____ (b) County _____
(c) City or town St. Louis Mo. 22
(If outside city or town limits, write "RURAL")
(d) Street No. 2812a Clark.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14th
year 1939 hour 8:40 minute _____ M.

21. I hereby certify that I attended the deceased from 11/17, 1939, to 12/14, 1939
that I last saw her alive on 12/14, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions Tuberculosis Laryngitis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. Maxwell (M. D. or other) _____
Address 5600 Arsenal St. Date signed 12/19/39

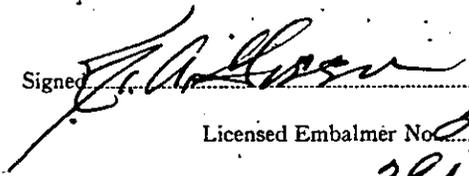
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 2963

P. O. Address. 29 Franklin

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 this body is not embalmed, above space should be left blank.