

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **9506**

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
DePaul Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Wk.**
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5387 Queens**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

FILED DEC 11 1940

3. (a) PRINT FULL NAME **Katherine A. Watson**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov.** day **19**
 year **1940** hour **12** minute **30 A.** M.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **William Watson** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Mar. 28, 1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 1, 1940**
 _____, 19 **40** to **Nov. 19**, 19 **40**
 that I last saw her alive on **Nov. 18**, 19 **40**
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 **7** **21** hr. _____ min.

Immediate cause of death
Carcinoma of the head of the parotid
 Due to _____
 Due to _____
 Other conditions **Generalized metastases**
(Include pregnancy within 3 months of death)

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

Major findings:
 Of operations _____
 Of autopsy _____

MOTHER FATHER { 11. Industry or business _____
 12. Name **Valentine Kerner**
 13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Cotter**
 15. Birthplace **Md.**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Cotter Watson**
 (b) Address **5387 Queens**
 17. (a) **Burial** (b) Date thereof **11-21-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cem.**

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? _____

18. (a) Signature of funeral director **Jay B. Smith**
 (b) Address **7456 Manchester**
 19. (a) **NOV 19 1940** (b) _____
(Date received local registrar) (Signature of Registrar)

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature **John G. M. Survey** (M. D. or other) **MD**
 Address **2014 Thebes Av** Date signed **11/19/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

*McC Sweeney
4701 a
SP Louis*

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 *J. A. Burgess*

Licensed Embalmer No. *4029*

P. O. Address *Maplewood*

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, fact should be so stated above.