.2
1-41
..39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 7 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32490

Registration District No. 184 Primary Registration District No. 01 Registrar's No. 1975

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 hr. 55 min. (Specify whether years, months or days)
In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 096
(c) City or town Kirkwood (If outside city or town limits, write "RURAL") 4
(d) Street No. West View & Emerson (If rural, give location) 3
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Watts, Baby Girl Dorothy
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 14 (Day) 1941 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 9 hr. 55 min.

9. Birthplace Clayton (City, town, or county) Mo. (State or foreign country)
10. Usual occupation none
11. Industry or business
12. Name Clinton Elvis Watts (FATHER)
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)
14. Maiden name Elsie Strubinger (MOTHER)
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Hosp Record
(b) Address
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-24-41 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis Crematory
18. (a) Signature of funeral director D. C. Hoffmann
(b) Address St. L. Crmt. Hosp. Clayton, Mo.
19. (a) SEP 24 1941 (Date received local registrar) (b) C. L. McGahan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14 year 1941 hour 10 minute 10 A. M.
21. I hereby certify that I attended the deceased from 9-14-41, 19..., to 9-14-41, 19..., that I last saw her alive on 9-14-41, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity — Duration 5½ hrs
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. B. Vatterott M.D. (M.D. or other)
Address St Louis C Hosp. Date signed 9-15-41

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32490

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1975

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St L. Co Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 hr 55 min (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. West Ones Emerson
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Watts, Baby Girl
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 14 (Day) 1941 (Year)
8. AGE: Years | Months | Days | If less than one day 9 hr. 55 min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-24-41 (Date received local registrar) (b) E L McGavran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY