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FILED MAY 25 1944

Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
(Specify whether years, months or days) 12 Days

3. (a) PRINT FULL NAME EMMA JANE WATTS

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 Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 28 1875
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Henry B Fields
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Laura Anderson
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Bann

(b) Address Elsberry Mo

17. (a) Burial (b) Date thereof 5-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mo

18. (c) Signature of funeral director W. B. Bradley

(b) Address Elsberry Mo

19. (a) MAY 16 1944 (b) J. Beebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln 57
(c) City or town Elsberry NR
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1944 hour 2 minute 5 P.M.

21. I hereby certify that I attended the deceased from May 2, 1944 to May 14, 1944
that I last saw her alive on May 14, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral degeneration Duration

Due to arteriosclerotic heart disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

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 W. B. Bradley (M. D. or other) BARNES HOSPITAL
Address Elsberry Mo Date signed 5/15/44

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

MOTHER, FATHER

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

W D Bradley

Licensed Embalmer No.....

3966

P. O. Address

Elsherry

Me

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.