V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26660

FILED SEP 8 1944 318

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 7312

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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 11 Mins. (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 3012 Lucas Ave. 21
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Shirley Jean Watson

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased 8 (Month) 2 (Day) 44 (Year)

8. AGE: Years ____ Months ____ Days ____ If less than one day hr. 11 min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

12. Name ____

13. Birthplace ____ (City, town, or county) ____ (State or foreign country) 7

14. Maiden name Ernestine Watson

15. Birthplace Caruthersville (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Esther M. Sherrard RN

(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG 24 1944 (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Janice Owens

(b) Address City Health Dept

19. (a) AUG 23 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 2 year 44 hour 12 minute 19 P.M.

21. I hereby certify that I attended the deceased from 8 - 2, 1944, to 8 - 2, 1944 and that I last saw her alive on 8 - 2, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis; Ascites — Duration

Due to Unknown

Due to Unknown

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? ____

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

23. Signature H. H. Sembler (M. D. or other) 0

Address 2601 N. Whittier St. Date signed 8-21-44

(Licensed Embalmer's Statement on Reverse Side)

7312

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.