

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

FILED DEC 9 1944

Registration District No. 336

Primary Registration District No. 4521

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Baytown Houston
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Texas
(c) City or town Houston
(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 _____

3. (a) PRINT FULL NAME Anna Christina Watson

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

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

6. (b) Name of husband or wife Charley 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased April 17 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo. U
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Bockstruck

13. Birthplace Germany U
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Charley Watson

(b) Address Houston Tx

17. (a) Burial (b) Date thereof 11/19/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Houston

18. (a) Signature of funeral director Gaylord D. Elliott

(b) Address Houston Tx

19. (a) Nov. 30 1944 (b) Mrs. Ella Duff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6
year 1944 hour 1 minute 9 P. M.

21. I hereby certify that I attended the deceased from FCB 1943 to NOV 6 1944
that I last saw her alive on NOV 6 1944
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCLUSION
Due to HYPERTENSIVE CARDIO-RENAL VASCULAR DISEASE

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
131a

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) Means of injury 5
23. Signature M. D. or other H. D.
Address Houston TX signed 11-11-44

RECEIVED

District Health Officer No. 5,40

District File Number 1244540

Date Filed 12-8-44

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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, Tex

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 356

Primary Registration District No. 4221

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Houston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Anna C. Watson

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased April 17 (Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 17 If less than one day, _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(Place: burial or cremation)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____ day _____ year _____ 19____ M. _____ minute _____

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

39839

1940