

FILED JAN 6 7 1945

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 425-

1. PLACE OF DEATH:

(a) County: Callaway

(b) City or town: Fulton

(c) Name of hospital or institution: State Hosp #1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution: time 10-15-40  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: 14

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

(d) Street No.: 1716a manard ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: Julia K. Watson

3. (b) If veteran, name war: DK

3. (c) Social Security No.: DK

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec, day: 27  
year: 1944, hour: 6, minute: 30 a M.

21. I hereby certify that I attended the deceased from 11-20 1944 to 12-27 1944  
that I last saw her alive on 12-26 1944  
and that death occurred on the date and hour stated above.

4. Sex: Female 5. Color of race: W

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife: Nelson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Month) (Day) (Year)

7. Birth date of deceased: Jan 23 1860  
(Month) (Day) (Year)

Immediate cause of death: chronic myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years: 84 Months: 2 Days: 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: 11 - Louisville, Ky.  
(City, town, or county) (State or foreign country)

10. Usual occupation: None

11. Industry or business: \_\_\_\_\_

MOTHER FATHER { 12. Name: D. T. Kaiser

13. Birthplace: DK Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name: DK Unknown

15. Birthplace: DK Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant: Ronald Agnes Dooley

(b) Address: 4537 Shenandoah Ave.

17. (a) Burial (b) Date thereof: Dec. 30, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Sunset Burial Park

18. (a) Signature of funeral director: Wacker-Heldre  
(b) Address: 3634 Gravois Ave.

19. (a) 12-27-1944 (b) Jose Moravetz  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_

Of operations: 93h

Of autopsy: \_\_\_\_\_

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: K. E. Starnes (M. D. or other)

Address: Fulton Mo Date signed: 12/27/44

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

14  
1  
2

JAN 6 1945

*Janice Mearns Schmitt Registrar*  
*Chickens No.*

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-5-45

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 Robert C. Wheeler

Licensed Embalmer No. 2178

P. O. Address St Louis Mo

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.