. S. No. 2
0M—2-43
ev. 5-17-39
I X35693

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42537

FILED JAN 12 1946

Registration District No. _____ Primary Registration District No. 6026 Registrar's No. 12

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison 62

(c) City or town Mine Lamotte 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Noel WATTS

3. (b) If veteran, name war World War II

3. (c) Social Security No. Unk.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Unk. 9

6. (b) Name of husband or wife Unk.

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased Dec. (Month) 8 (Day) 1909 (Year)

8. AGE: Years 36 | Months 0 | Days 22 | If less than one day _____ hr. _____ min.

9. Birthplace Mine Lamotte (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business _____

FATHER
12. Name Louis Watts
13. Birthplace Yount (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Elizabeth Kennedy
15. Birthplace Desmond Cross (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Clinical Records, Vet. Admin.
(b) Address Hospital, Jefferson Barracks, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation Fredericktown, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 1-4-46 (Date received local registrar) (b) [illegible] M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30 year 1945 hour 9:25 minute A. M.

21. I hereby certify that I attended the deceased from December 30, 1945, to December 30, 1945 that I last saw him alive on December 30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death FRACTURE, LEFT FEMUR; PUNCTURE WOUND, LEFT ARM AND INTERNAL INJURIES — Duration

Due to Automobile accident

Due to -

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 62

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence December 30, 1945

(c) Where did injury occur? Public Highway (City or town) (County) Missouri (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)

While at work? No (e) Means of injury Collision of Autos.

23. Signature Harvey E. Sisk HARVEY E. SISK, Major, M.C., U.S.A. (M. D. or other)

Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 12/31/45

707 (Licensed Embalmer's Statement on Reverse Side)

FEB 20 1947

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 Elmo R. Caldwell

Licensed Embalmer No. 4077

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.