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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1066

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 167

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

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: St. Marys Infirmary 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether
In this community Life Time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 1117
(If outside city or town limits, write "RURAL")

(d) Street No. 4210 West Belle Pl. 9
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Dorothy Brame Watkins

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased September (Month) 24th (Day) 1902 (Year)

8. AGE:

Years	Months	Days	If less than one day
43	3	10	hr. min.

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

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Edward Brame
13. Birthplace Shelbyville Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Della Spinner
15. Birthplace St. Charles Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Algo Brame
(b) Address 4210 West Belle Pl.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (Month) (Day) (Year)
(c) Place: burial or cremation St Peters Cemetery

18. (a) Signature of funeral director C. W. Roberts
(b) Address 1416 North Taylor ave

19. (a) JAN 7 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 3
year 1946 hour 2 minute 30 a M.

21. I hereby certify that I attended the deceased from 12/24, 1945, to 1/3, 1946
that I last saw her alive on 1/3/46, 19
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Abscess of Brain - non-tuberculous 3 days

Due to Chronic Otitis Media

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy NO

Duration

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 0

23. Signature [signature] (M. D. or other)
Address [signature] Date signed 1/4/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 7

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.