o. 300
-10-47
-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 7 1948
Registration District No. 317

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 28424
Registrar's No. 1903

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: #45 Chafford Dr.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. #45 Chafford Dr.
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Alice B. Watson

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Will Watson
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased March (Month) 17 (Day) 1874 (Year)

8. AGE: Years 74 | Months 4 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Carthage (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____

FATHER
12. Name Unknown Mansfield
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Frank DeBolt
(b) Address #45 Chafford Dr.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-48 (Month) (Day) (Year)
(c) Place: burial or cremation Carthage, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 8-12-48 (Date received local registrar) (b) Paula J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9 year 1948 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1946 1946, 19__ to Present Present; that I last saw her alive on August 2 Aug 2, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease, Coronary Heart Disease
Due to ____
Due to ____
Other conditions Hypertension, Hypertension
(Include pregnancy within 3 months of death)
Major findings:
Of operations X
Of autopsy X

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 ____

23. Signature Pam A. Barrett (M. D. or other)
Address 1200 S. Big Bend Date signed 8-10-48

(Licensed Embalmer's Statement on Reverse Side)

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 Gustav W. Dietel

Licensed Embalmer No. 4329

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.