

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 1003

State File No. 25391
6274

BIRTH NO. 45976-50 REG. DIST. NO. HOMER G. PHILLIPS HOSPITAL Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis:		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hosp.		d. STREET ADDRESS (If rural, give location) 2609 Glasgow	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
Infant Watson			7	16	50
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE (In years last birthday)
			7-16-50		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Missouri	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		
			Loretta Watson		
14. NAME OF HUSBAND OR WIFE			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
			16. SOCIAL SECURITY NO.		
			17. INFORMANT'S SIGNATURE OR NAME Mrs. Arthur M. Sherrard		
			ADDRESS 2601 N. Whittier		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Premature birth			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS			
ANTECEDENT CAUSES		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP); (COUNTY); (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
				776X	

22. I hereby certify that I attended the deceased from 7-16-1950, to 7-16-1950, that I last saw the deceased alive on 7-16-1950, and that death occurred at 4:26 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 7-18-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JUL 22 1950		24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg	
				24d. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 22 1950 J B Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc. 414 Manchester Ave. St. Louis 10, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6274

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

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.