

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31934

State File No.

FILED SEP 22 1951

8031

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILL. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Du Quoin		9/20/51	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hosp.				d. STREET ADDRESS (If rural, give location) 218 So. Division			
3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY		b. (Middle) ANN		c. (Last) WATSON		4. DATE OF DEATH (Month) (Day) (Year) 9 - 7 - 51	
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH July 27, 1929	
9. AGE (In years last birthday) 22		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Christopher, Ill	
10a. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Dand Looney		13b. MOTHER'S MAIDEN NAME Neva Harrison	
13c. NAME OF HUSBAND OR WIFE James Watson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME James Watson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Glomerulonephritis, acute 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. Secondary Hypertension.				INTERVAL BETWEEN ONSET AND DEATH 6 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 590X			
22. I hereby certify that I attended the deceased from June 19, 51 , to Sept 7, 1951 , that I last saw the deceased alive on Sept 7, 1951 , and that death occurred at 2 P m., from the causes and on the date stated above.							
23a. SIGNATURE Walter W. Davis, MD				23b. ADDRESS 539 N. Grand		23c. DATE SIGNED 9/8/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-9-51		24c. NAME OF CEMETERY OR CREMATORY HARRISON		24d. LOCATION (City, town, or county) (State) Christopher, Ill.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE SEP 10 1951 J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service		ADDRESS 4304 Manchester Ave.			

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

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.....
.....
working under my personal supervision. Student Embalmer No.....

Signed.....
Student Embalmer

Signed *John Keller*
Licensed Embalmer No. *3880*
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.