

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21426**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5021**

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, MISSOURI.		c. LENGTH OF STAY (In this place) 6 days.	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		c. CITY OR TOWN ST. LOUIS, d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS #74 Vandeventer Place.. 2199		19	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) TORRENCE c. (Last) WATSON		4. DATE OF DEATH (Month) (Day) (Year) June 4, 1954	
5. SEX Male. <input type="radio"/>	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <input checked="" type="checkbox"/> Married.	8. DATE OF BIRTH Nov 18, 1902.
9. AGE (In years last birthday) 51.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist.		10b. KIND OF BUSINESS OR INDUSTRY presently unemployed.	
11. BIRTHPLACE (City and State or Foreign Country) <input type="radio"/>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Watson.		13b. MOTHER'S MAIDEN NAME Florence E. Rhodes.	
14. NAME OF HUSBAND OR WIFE Dorothy H. Watson.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.	
16. SOCIAL SECURITY NO. no.		17. INFORMANT'S SIGNATURE OR NAME Mrs J. T. Watson, #74 Vandeventer Place.	
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) <u>Acute Pharyngitis</u> ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Trachea Bronchitis</u> <u>Amyotrophic Lateral Sclerosis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 days	
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) 472.1		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>54</u> , to <u>June 4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>54</u> , and that death occurred at <u>8:05 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>F R Bradley</u>		23b. ADDRESS BARNES HOSPITAL	
(Degree or title) M.D. <u>9</u>		23c. DATE SIGNED 6-5-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Interment.		24b. DATE 6/7/54	
24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.	
DATE REC'D BY LOCAL REG. JUN 7 1954		REGISTRAR'S SIGNATURE <u>Carl Schmid MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE G. R. LUPTON & SONS.		ADDRESS #7233 Delmar Blv'd.,	

WRITE PLAINLY—USING 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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *461*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.