

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42929

10752

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital		STREET ADDRESS (If rural, give location) 15 4619 Virginia 2159	

3. NAME OF DECEASED (Type or Print) a. (First) E. b. (Middle) Marion c. (Last) Watson	4. DATE OF DEATH (Month) (Day) (Year) 11/23/54
---	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 24, 1877	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	--	---	---	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Marion, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME Charles Link	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE George W.
---	---	---

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. none	17. INFORMANT'S SIGNATURE OR NAME George W. Watson	ADDRESS 4619 Virginia
---	--	--	---------------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Phlebotomy bases rt. leg. Pulmonary Tbc arrested.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis, chronic		

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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 465X
--	--	---

22. I hereby certify that I attended the deceased from **11/19, 1954** to **11/23, 1954**, that I last saw the deceased alive on **11/23, 1954**, and that death occurred at **12:18 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles Knowles	23b. ADDRESS Mad. 16 Plaza Hampton	23c. DATE SIGNED 11-25-54
--	--	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/26/54	24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. NOV 26 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Kelderle	ADDRESS 3634 Gravois 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert Wheeler*.....

Licensed Embalmer No. *210*

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