

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14002

Registrar's No. 3300

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | State File No. 14002   |  | Registrar's No. 3300  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY _____ |  |  |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>  |  |  | c. LENGTH OF STAY (In this place) _____  |  |  | c. CITY OR TOWN <b>Saint Louis</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>   |  |  |  | STREET ADDRESS (If rural, give location)<br><b>3431 Lawton</b>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Lillie</b>   |  |  |  | b. (Middle) _____  |  | c. (Last) <b>Watson</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>4 8 55</b>  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  |  | 8. DATE OF BIRTH <b>Dec. 20, 1889</b>                                      |  | 9. AGE (In years last birthday) <b>65</b>   |  |
| IF UNDER 1 YEAR Months _____ Days _____   |  | IF UNDER 14 HRS. Hours _____ Min. _____  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>                         |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>Columbus, Mississippi</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |   |  |
| 13a. FATHER'S NAME <b>Andy Williams</b>   |  |  | 13b. MOTHER'S MAIDEN NAME <b>Unknown</b> |  |  | 14. NAME OF HUSBAND OR WIFE _____  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. _____  |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Edna Carter</b> ADDRESS <b>893 W. Euclid Detroit 2, Mich.</b>                                 |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  | MEDICAL CERTIFICATION  |  |  |  |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malnutrition; Peritonitis, Probable Ruptured Diverticulum of Sigmoid</b>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>  |  |  |  |   |  |
| * This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.   |  |  |  | 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 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) (m.) _____                 |  |   |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR? <b>578 X</b>  |  |  |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>3-23, 1955</b> , to <b>4-8, 1955</b> , that I last saw the deceased alive on <b>4-8, 1955</b> , and that death occurred at <b>8:30 A.m.</b> , from the causes and on the date stated above. |  |  |  |  |  |  |  |   |  |
| 23a. SIGNATURE <b>Frank O Richards</b>  |  |  |  | (Degree or title) <b>M.D.</b>  |  | 23b. ADDRESS <b>2601 N. Whittier</b>                                       |  | 23c. DATE SIGNED <b>4-12-55</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |  | 24b. DATE <b>4-14-55</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |  |   |  |
| DATE REC'D BY LOCAL REG. <b>APR 14 1955</b>   |  | REGISTRAR'S SIGNATURE <b>Carl Smith</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Metropolitan Funeral System, Inc. 5010 Enright Ave.</b>                                |  |  |  |   |  |

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 *Paul V. Francon*

Licensed Embalmer No. *468*

P. O. Address *4729 Hammet*

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.