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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007760
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2162

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MARIAN HOSPITAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS: 3949 HARTFORD (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: LIZZIE Middle: Last: WATSON

4. DATE OF DEATH: Month FEB Day 28 Year 1959

5. SEX: FEMALE 6. COLOR OR RACE: WHITE 7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 3 DIVORCED ☒

8. DATE OF BIRTH: OCT 11 1872

9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (City and state or country): TENNESSEE
12. CITIZEN OF WHAT COUNTRY?: U-S-A

13a. FATHER'S NAME: JAMES WATSON
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: BERNICE MILLER Address: 3949 HARTFORD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RIGHT LOBAR PNUEMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE — 2 YEARS
DUE TO (c) 4280
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from JULY 1957 to 2-28-59 and last saw her alive on 2-28-59
Death occurred at 5:26 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: O. J. Jones (Degree or title) MD
22b. ADDRESS: 3616 S. BROADWAY - ST. LOUIS
22c. DATE SIGNED: 3-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: MAR 3 1959
23c. NAME OF CEMETERY OR CREMATORY: MOUNT HOPE CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: MAR 2 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MBB

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 [illegible]

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.