URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042687

FILED VS NOV 30 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210654 STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS, MISSOURI — Length of stay in 1b

c. CITY OR TOWN 3018 RUTGER — Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS CITY HOSP # 1 — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS ST. LOUIS, MO (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: BABY GIRL (LATERYLE DARCLE) WATSON

4. DATE OF DEATH Month Day Year: NOVEMBER 4th 1959

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11/4/59

9. AGE (last birthday) — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.: 9 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (City and state or country): st. louis, mo

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: UNKNOWN

13b. MOTHER'S MAIDEN NAME: FREDDIE WATSON

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (Yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: ST. LOUIS CITY HOSP. #1.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Prematurity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 Nov. 4, 1959, to Nov. 4, 1959 and last saw her/him alive on Nov. 4, 1959

Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. James Vaccarella M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 11-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 11-30-59

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Rowland Aker 4104 Manchester

25. DATE RECD. BY LOCAL REG.: NOV 19 1959

26. REGISTRAR'S SIGNATURE: Karl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.