

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028913

FILED 15 AUG 8 1960

Registration-District No. **318** Primary Registration District No. **1003** Registrar's No. **7428** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If outside, give location) 4026 Nebraska	

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle WATKINS Last			4. DATE OF DEATH Month July Day 25th Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-13-93	9. AGE (last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Formerly: Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	

13a. FATHER'S NAME Geo. Schaffner		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE Bert Watkins	
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 Eleanor Wilkes Address 9607 E 77th St Raytown, Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 420.1	
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
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 Jan. 28, 1916 and last saw her ^{her} him alive on July 25, 1960			
Death occurred at 7:30^{AM} on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L.N. McCullough, M.D. (Degree or title)	22b. ADDRESS 5400 Arsenal St.		
22c. DATE SIGNED 7-25-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 28 1960	23c. NAME OF CEMETERY OR CREMATORY St Paul Churchyard	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. JUL 26 1960	26. REGISTRAR'S SIGNATURE Heard Smith, M.D. <i>2198</i>
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jara

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