

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 5035 Minerva	

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Watson Last Watson			4. DATE OF DEATH Month 9 Day 12 Year 60			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1904	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) MO	12. CITIZEN OF WHAT COUNTRY U. S. A
13a. FATHER'S NAME JOSEPH BASBY	13b. MOTHER'S MAIDEN NAME JOSEPHINE LARQUE	14. NAME OF HUSBAND OR WIFE EDGAR WATSON	
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. ---	17. INFORMANT Address EDGAR WATSON 5035 MINERVA	

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) Hemorrhage			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Meningeal		
	DUE TO (c) metastasis.		Undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171x			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.) 171x
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---------------------------------------------------	------------------

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 POTOSI MO
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------

21. I attended the deceased from 4-13-60 to 9-12-60 and last saw her/him alive on 9-12-60
* Death occurred at 3:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm Smitley, M.D. (Degree or title)	22b. ADDRESS 4105 - a - Easton	22c. DATE SIGNED 9-13-60
----------------------------------------------------------	---------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9/16/60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) POTOSI MO
-------------------------------------------------------------	-----------------------------	------------------------------------	-------------------------------------------------------------------

24. FUNERAL DIRECTOR SWAN-MORHEE UND. CO 1619 N.	25. DATE RECD. BY LOCAL REG. SEP 14 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
------------------------------------------------------------	----------------------------------------------------	------------------------------------------------------

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 Edward A. Flynn

Licensed Embalmer No. 4444

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.