

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-013306

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2884

FILED MAR 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>---</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>---</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>7 yr 3 mo</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>223 West Robert Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Anna</u> Last <u>Watkins</u>			4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (last birthday) <u>98</u> IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> IF UNDER 24 HR: Hours <u>---</u> Min. <u>---</u>
11a. BIRTHPLACE (City and state or country) <u>Johnstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Watkins</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline H. Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>---</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Masonic Home of Mo. 5351 Delmar Blvd.</u> <u>Carl S. Allen</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			<u>4 YRS</u>
DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u>			<u>4 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NONE</u>			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.) <u>420.0</u>	
20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u>		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.) <u>---</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>---</u>	
21. I attended the deceased from <u>Dec 21, 1957</u> to <u>MARCH 13, 1962</u> and last saw her <u>alive</u> on <u>MARCH 13, 1962</u> Death occurred at <u>9:55</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert C. Hall, M.D.</u>		22b. ADDRESS <u>3902 LAFAYETTE, ST. LOUIS 10, MO</u>	22c. DATE SIGNED <u>MARCH 14, 1962</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>HOFFMIESTER COLONIAL MORTUARY</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 15 1962</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>

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 Bill C. Johnson

Licensed Embalmer No. 4764

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.