

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH791
100830496
Do not use this space.

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1. PLACE OF DEATH

(a) County.....
 (b) Township.....
 (c) City St. Louis, Mo. (d) Street No. St. Louis Maternity Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Dixon, Infant 250
 (a) Residence, No. 1125 No 6th St. Mount Vernon
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>600 pm</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>August 27, 1938</u>		
7. AGE YEARS	MONTHS	DAYS
<u>Stillborn</u>		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Mo.</u>		
13. NAME <u>Dixon, Claire Maurice</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sims, Illinois</u>		
15. MAIDEN NAME <u>Montane, Lucille Adele</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Yuba City, California</u>		
17. INFORMANT (ADDRESS) <u>Claire Maurice Dixon</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dept of Pathology Wash Univ</u> DATE <u>10-28</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Washington Univ</u>		
20. FILED <u>SEP - 8 1938</u> <u>J. F. Brubaker</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 6 1/2 m.
 The principal cause of death and related causes of importance were as follows:
9 hydrocephalus
48 hrs post op
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19____
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify Cells 15 Schwarz
 (Signed) J. F. Brubaker, M. D.
 (Address) St. Mat. Hosp

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)