

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13231
Do not use this space.
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REC'D MAY 10 1939

791
1003

1. PLACE OF DEATH

(a) County..... / Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No.....
 (c) City St. Louis, Mo. / (d) Street No. St. Louis Children's 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 Gwendolyn Kay Dixon

(a) Residence, No. St. Clair, Mo. St. MR St. Clair, Mo.
 (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>F.</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>child</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>child</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>4-10-39</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>child</u>		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. Clair, Mo.</u>		
13. NAME <u>Carl L. Dixon</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Festus, Mo.</u>		
15. MAIDEN NAME <u>Erma Short</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Clair, Mo.</u>		
17. INFORMANT (ADDRESS) <u>Erma</u>		
18. BURIAL, CREMATION OR REMOVAL PLACE <u>St. Clair Mo.</u> DATE <u>4-16-39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Shannon Kitchell</u> <u>St. Clair Mo.</u>		
20. <u>APR 18 1939</u> Local Registrar. <u>J. B. Beck</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15 1939

22. I HEREBY CERTIFY, That I attended deceased from April 15 1939 to April 15 1939
 I last saw her alive on April 15 1939. Death is said to have occurred on the date stated above, at 10:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Haemorrhage
Meningitis non purulenta
 Date of onset 14-4-39

Other contributory causes of importance:
160 lb

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

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..... (Signed) R. D. Blatter, M. D.
 (Address) 500 So Kings Highway

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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

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.