

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

8872
2355

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hos'p
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
 In this community 3 years 7 months (Specify whether years, months or days)

8. (a) PRINT FULL NAME Darothy Dickerson
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 18, 1936
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 7 25 12 hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER
 12. Name Dowell Dickerson
 13. Birthplace Poplar Bluff Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Ella Prier
 15. Birthplace Poplar Bluff Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dowell Dickerson
 (b) Address 1119 St. Louis Ave
 17. (a) 1 Burial Co. (b) Date thereof 3/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Licking Mo.

18. (a) Signature of funeral director Smith & Ferguson
 (b) Address Licking Mo.

19. (a) MAR 11 1940
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis Mo. 26
(If outside city or town limits, write "RURAL")
 (d) Street No. 1119 St. Louis Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 10
 year 1940 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death 1st 2nd 3rd degree Duration
burning of head & body surface
when sleeping became paralyzed
 Due to spontaneous thrombosis of the
arteries in her home about
 Due to 10:25 A.M. Mar 5 1940

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 18/15

Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence Mar 5 1940
 (c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place)
 (a) Means of injury Burn

23. Signature John Perry (M. D. or other)
 Address 1119 St. Louis Ave Date signed 3/11/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
U. S. G. P. 1 X18811

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.

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

J. S. Sullivan

Licensed Embalmer No. 1122

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.