

3-40
7-39
K23159

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **8835**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5551 Chamberlain
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **THOMAS QUINTIN DIX**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Clara** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **December 17 1866**
(Month) (Day) (Year)

8. AGE: Years **73** Months **10** Days **8** If less than one day
hr. _____ min _____

9. Birthplace **Essex England**
(City, town, or county) (State or foreign country)

10. Usual occupation **retired** **4**

11. Industry or business **oil mfg.** **4**

12. Name **Quintin Wm. Dix** **4**

13. Birthplace **England**
(City, town, or county) (State or foreign country)

14. Maiden name **Amelia Jane**

15. Birthplace **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chester B. Dix**

(b) Address **5551 Chamberlain**

17. (a) **burial** (b) Date thereof **10/28/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **West Bellefontaine**

18. (a) Signature of funeral director **Allyson B. Row**

(b) Address **6175 Hillmer**

19. (a) **OCT 27 1940** (b) **J. P. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St Louis** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. **5551 Chamberlain**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **25**
year **1940** hour **8:00** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Feb. 1940**
_____, 1940, to **Oct 25**, 1940
that I last saw him alive on **Oct 24**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**
Carcinoma of Rectum **10 days**

Due to **Urinary Suppression**

Due to _____

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

Major findings: Of operations **Carcinoma Sigmoido-Rectal Junction**
Of autopsy **None**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature **Paul K. Webb M.D.** (M. D. or other)
Address **Chemical Bldg.** Date signed **Oct 25 1940**

View record

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

Robert E. White, Registered Apprentice No. 209
working under my personal supervision.

Signed Joe E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar
At Long Beach

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.