

Registration District No. 318

Primary Registration District No. 1003

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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
12 hrs.
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Mary L. Dixon

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 43 Miss. hr. min.

9. Birthplace Aberdeen, (City, town, or county) (State or foreign country)

10. Usual occupation Hairdresser

11. Industry or business.....

12. Name Tom Dixon

13. Birthplace West Point, (City, town, or county) (State or foreign country)

14. Maiden name Rose Anna Brooks

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

16. (a) Informant Georgia Franklin (b) Address 4215E. Evans-Ave.

17. (a) Burial (b) Date thereof 10 22 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetary

18. (a) Signature of funeral director A. L. Bege (b) Address 2726 Spruce Ave
19. (a) OCT 27 1943 (b) J. F. Bedack
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County 17
(c) City or town St. Louis mo 9 21
(If outside city or town limits, write "RURAL")
(d) Street No. People's Finance Bldg
44th & Market Streets (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 18
year 43 hour 6 minute 50 A

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....
Lobar Pneumonia
Primary

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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 Alfred J. Perry (M. D. or other) 2
Deputy Coroner
Address..... Date signed 10/20/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

4-2-21

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 *Arthur L. Hilliard*
Licensed Embalmer No. *4221*
P. O. Address *4219^e E. Garfield*

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, fact should be so stated above.