

FILED MAR 13 1944 818

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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

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: **JEWISH HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **MYRTLE DAWSON**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed  married divorced **1**  
6. (b) Name of husband or wife **WILLIAM A. DAWSON** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **SEPT 15 1887**  
(Month) (Day) (Year)

8. AGE: Years **62** Months **5** Days **16** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **JOPLIN MO. O**  
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business \_\_\_\_\_

12. Name **TOM McEFFEE**  
13. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country)  
14. Maiden name **EDDIE**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Clyde Osborn (son)**  
(b) Address **2812 Wheaton Overland Mo.**

17. (a) **Burial** (b) Date thereof **3-4-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LAKE CHARLES CEM**

18. (a) Signature of funeral director **Lawrence Mullen**

(b) Address **5165 Rebnars Blvd.**

19. (a) **MAR 3 1944** (b) **J. F. Bredeck**  
(Date received local facilities) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St. Louis**  
(c) City or town **Overland** (If outside city or town limits, give location)  
(d) Street No. **2812 Wheaton N.R.** (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **1**  
year **1944** hour **10** minute **P** M.

21. I hereby certify that I attended the deceased from **July 1943** to **Mar 1 1944**  
that I last saw her alive on **Mar 1 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death **gangrene of large bowel 2 days**  
Due to **Obstruction at distal end**

Due to \_\_\_\_\_  
Other conditions **1943**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy **gangrene of large intestine**

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) (c) Means of injury **8**

23. Signature **Julius Kapp** (M. D. or other) **MD**  
Address **4500 Olive** Date signed **3/2/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... *H. G. Harris*.....  
Licensed Embalmer No. *3384*.....  
P. O. Address..... *H. Harris*.....

**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.**