

FILED OCT 7 1946

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days
(Specify whether years, months or days) 32 yrs

3. (a) PRINT FULL NAME Paul Dickson

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

4. Sex Male, 5. Color or race e

6. (a) Name of husband or wife Rebecca Pearl 6. (b) Single, widowed, married, divorced married

7. Birth date of deceased 7-14-1885 6. (c) Age of husband or wife if alive 65 years

8. AGE: Years 61 Months 2 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Chau Peur

11. Industry or business none

MOTHER FATHER { 12. Name George Dickson

{ 13. Birthplace Desoto Mo. (City, town, or county) (State or foreign country)

{ 14. Maiden name Elizabeth Christopher

{ 15. Birthplace Mobile La. (City, town, or county) (State or foreign country)

16. (a) Informant Wife Rebecca Dickson

(b) Address 1608 S. Hanley, Richmond

17. (a) BURIAL (b) Date thereof 1946

(c) Place: burial or cremation GREENWOOD CEM.

18. (a) Signature of funeral director John E. Keller

(b) Address 3080 Bell Ave

19. (a) 9-25-46 (b) Paul Dickson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 1608 S. Hanley
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21st
year 1946 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from August 27th 1946 to September 21 1946
that I last saw him alive on September 21st 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 John Keller (M. D. or other) MD

Address 601 Brentwood Date signed 9-22-46

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.....

Escher H. Harris

Registered Apprentice No. *416*

working under my personal supervision.

Signed *W. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alameda*

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.

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days
(Specify whether years, months or days)

In this community.....
years, months or days)
3. (a) PRINT FULL NAME Paul Dickson
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased July (Month) 1946 (Day) 1946 (Year)

8. AGE: Years 61 Months 15 Days 15 If less than one day.....
9. Birthplace MO (City, town, or county) (State or foreign country)

10. Usual occupation.....
11. Industry or business.....
MOTHER FATHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....
19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 16085 Harvey
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH Month September Day 24 year 1946 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 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 Carcinomatous
abdominal type
unknown
Due to.....
Due to.....
Other conditions.....
(include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

USE UNFADING INK—MAKE A PERMANENT RECORD.

30702

