

National Office of Vital Statistics
FILED JAN 16 1948

1003

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Registration District No. 218

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County..... St. Louis MO.
 (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..... City Infirmary Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... 3-26-46 to 1-1-48
 (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT FULL NAME..... Susan Dixon
 3. (b) If veteran, name war..... No
 3. (c) Social Security No..... None

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, widowed, married, divorced..... Widow
 6. (b) Name of husband or wife..... Harry Dixon
 6. (c) Age of husband or wife if alive..... 1877
 7. Birth date of deceased..... July 2 1877
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 70 6 2 hr. min.

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

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Patrick Flannigan

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

14. Maiden name..... Susan McDermott

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

16. (a) Informant..... Harry Dixon
 (b) Address..... 3926 Bates St. ST

17. (a) Burial (Burial, cremation, or removal)
 (b) Date thereof..... 1-7-48
 (Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary Cemetery

18. (a) Signature of funeral director..... Albert H. Hoppe

(b) Address..... 4700 Washington Blvd.

19. (a) Date received by Registrar..... JAN 5 1948
 (b) Registrar's signature..... J. F. Brebeck

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....
 (c) City or town..... St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No..... 5800 Arseanl St.
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Jan. day..... 4
 year..... 1948 hour..... 10 minute..... 35A.M.

21. I hereby certify that I attended the deceased from July 1st, 1947 to July 1-4, 1948 that I last saw her alive on July 1-4-48 1948 and that death occurred on the date and hour stated above.
 Duration

Immediate cause of death.....
 Arteriosclerotic heart disease with terminal decomposition

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

Major findings:
 Of operations.....
 Of autopsy.....
 PHYSICIAN
 Underline the cause of 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?.....
 (Specify type of place)

While at work..... Means of injury.....

23. Signature..... M. P. Shorney
 (M.D. or other)

Address..... 5800 Arseanl Date signed..... 1-5-48

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

MOTHER FATHER

[Handwritten signature]

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..... *[Handwritten signature]*.....
Licensed Embalmer No..... *3575*.....
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, fact should be so stated above.