

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6107**
Registrar's No. **1293**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

MOR

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) East St. Louis	
c. LENGTH OF STAY (in this place) 3 Days		d. STREET ADDRESS (If rural, give location) 1824 Bond Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary			

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Dixon			4. DATE OF DEATH (Month) (Day) (Year) Feb. 7, 1949		
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH May 7, 1917		9. AGE (In years last birthday) 31		10. IF UNDER 1 YEAR Months 9 Days 0	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY			

13a. FATHER'S NAME W. K. Harris		13b. MOTHER'S MAIDEN NAME Unavailable		14. NAME OF HUSBAND OR WIFE Willie Dixon	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Willie Dixon, 1824 Bond, E. St. Louis	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis - Toxic		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Reyter's Pelvic Infection		DUE TO (c) No pregnancy	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **6/7** 19**49**, to **1/7** 19**49**, that I last saw the deceased alive on **1/7** 19**49**, and that death occurred at **3:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edgar F. Warden		23b. ADDRESS 930 N 2nd St		23c. DATE SIGNED 2/8/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/9/49		24c. NAME OF CEMETERY OR CREMATORY Booker Washington		24d. LOCATION (City, town, or county) (State) St. Clair County, Ill.	
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DATE REC'D BY LOCAL REG. FEB 10 1949		REGISTRAR'S SIGNATURE J. B. Fasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. McC. Green	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, Mo

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.