

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19321

State File No.

5039

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		a. STATE Missouri	b. COUNTY Warren
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Warrington	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) Katie Jane Memorial Home	

3. NAME OF DECEASED (Type or Print) ARCH	a. (First)	b. (Middle)	c. (Last) DAWSON	4. DATE OF DEATH (Month) (Day) (Year) APRIL 30, 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH Nov. 30, ?	9. AGE (In years last birthday) 65?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spot welder	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Canada 2	12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Joseph	13b. MOTHER'S MAIDEN NAME Mary	14. NAME OF HUSBAND OR WIFE Thelma - ex-wife
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Hospital Record ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL THROMBOSIS	DUE TO (b) CEREBRAL ARTERIOSCLEROSIS		
II. OTHER SIGNIFICANT CONDITIONS CHRONIC BRAIN SYNDROME	DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Associated with CEREBRAL ARTERIOSCLEROSIS	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X

22. I hereby certify that I attended the deceased from **11-25-50**, 19___, to **4-30-53**, 19___, that I last saw the deceased alive on **4-30-53**, 19___, and that death occurred at **2:00P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edwin H. Schmidt, M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 5-1-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 5-30-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. MAY 19 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
48

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.