

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33108**
Registrar's No. **9387**

BIRTH NO. **64143** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 191 4122 Delmar Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity			

3. NAME OF DECEASED (Type or Print) a. (First) Dixon b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) September 18 1953	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH September 18 1953
9. AGE (In years last birthday) 1 10. UNDER 1 YEAR Months 1 11. UNDER 1 MIN. Days 25		11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME Mattie Dixon	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mattie Dixon
		ADDRESS 4122 Delmar St Louis Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity-incompatible life		
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature rupture of membranes DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 7615

22. I hereby certify that I attended the deceased from **Sept 18, 1953**, to **Sept 18, 1953**, that I last saw the deceased alive on **Sept 18, 1953**, and that death occurred at **10:15 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE Thompson MD	(Degree or title)	23b. ADDRESS Maternity Hospital	23c. DATE SIGNED 9-19-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 9-30-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. SEP 30 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Rowland	ADDRESS 4104 Manchester
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

FILED OCT 15 1953

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 _____

Licensed Embalmer No. _____

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.