

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2716

FILED FEB 2 1954

State File No. \_\_\_\_\_

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2645 PENNSYLVANIA 17</u>				e. STREET ADDRESS (If rural, give location) <u>2645 PENNSYLVANIA 2111 D</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u> b. (Middle) <u>H.</u> c. (Last) <u>DIMOCK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 21 1954</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MAY 6 1883</u>		
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEB PRESSMEN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>STAR TIMES</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CONNECTICUT</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>ROBERT H. DIMOCK</u>			13b. MOTHER'S MAIDEN NAME <u>NELLIE KENNEDY</u>		14. NAME OF HUSBAND OR WIFE <u>ROSE DIMOCK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ROSE DIMOCK 2645 PENNSYLVANIA</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uraemia</u>  ANTECEDENT CAUSES DUE TO (b) <u>Chronic nephritis, endocarditis</u> DUE TO (c) <u>arterio sclerosis general</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>2 years</u>  <u>2 years</u>
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>592X</u>				
22. I hereby certify that I attended the deceased from <u>12-22-52</u> to <u>1-21</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1-21-1954</u> , and that death occurred at <u>7:40 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>W. Simpson M.D.</u> (Degree or title)				23b. ADDRESS <u>3739 Gravois</u>		23c. DATE SIGNED <u>1-22-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JAN 23 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LAKEWOOD PARK</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>J. C. Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kute 2906 Gravois</u>		ADDRESS _____				

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

.VS AUG 14 1959

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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.....  
Signature of Student Embalmer

Signed..... *Leo J. Burdette* 3

Licensed Embalmer No.....

P. O. Address..... *St. Louis*

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.