

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 17 1956

State File No. **6355**  
877  
Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>6355</b> 877	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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 <b>BARNES HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>4722 McMillian</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Clara</b>		b. (Middle) <b>Alice</b>		c. (Last) <b>Dawkins</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 24, 1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 28, 1914</b>	
9. AGE (In years last birthday) <b>41</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Memphis, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Andrew Jones</b>		13b. MOTHER'S MAIDEN NAME <b>Katie Pride</b>		14. NAME OF HUSBAND OR WIFE <b>Jerry Dawkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489-12-5410</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Katie Gibson 4722 McMillian</b>			
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) <b>Ruptured Internal Carotid Aneurysm</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>452x</b>	
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? _____			
22. I hereby certify that I attended the deceased from <b>Jan. 13, 1956</b> , to <b>Jan. 24, 1956</b> , that I last saw the deceased alive on <b>Jan. 21, 1956</b> , and that death occurred at <b>8:05A m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>C. P. McMillian, M.D.</b> M. D.				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>1/25/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-30-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo</b>	
DATE REC'D BY LOCAL REG. <b>JAN 26 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b> S.P.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>English Undert. C. 1123N. Taylor Ave.</b>			

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

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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 *William R. Williams*

Licensed Embalmer No. *492*  
*4554 Lexington*  
P. O. Address .....,  
*City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.