

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019927

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 1360

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		c. CITY OR TOWN <u>University City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Home</u>		d. STREET ADDRESS (If outside, give location) <u>830 Warder Ave</u>	
Length of stay in lb <u>2 weeks</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>DELL</u> Last <u>DIXON</u>			4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 7, 1868</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Forrest, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Barak Bullard</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Hoover</u>		14. NAME OF HUSBAND OR WIFE <u>unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Harvey E. Dixon 830 Warder U. City, Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rt. Breast, c</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>general metastases.</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from Feb 15 1959 to May 16 1959 and last saw her <sup>her</sup> alive on May 16 1959.  
Death occurred at 6:20 P. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dee or title) <u>Ed Seabaugh M.D.</u>		22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>5/18/59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>5/19/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forrest City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Forrest, Illinois</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton and sons 7233 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>5-18-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. MUST USE ONLY STANDARD NOMENCLATURE IN ITEM 18. NO symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

RAIL

until 10:00 P.M.

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 Arnold W. Schoen

Licensed Embalmer No. 3864  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.