IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-012509

FILED VS MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 3319 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Oklahoma b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Saint Louis — Length of stay in 1b: 6 wks

c. CITY OR TOWN: Lawton — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Mary's Infirmary — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): #7 Bell Avenue — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ANTHONY Middle M. Last DIXON

4. DATE OF DEATH: Month March Day 21 Year 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 1/30/97

9. AGE (last birthday): 63 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (City and state or country): Chapell Hill, Texas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Richard Browning

13b. MOTHER'S MAIDEN NAME: Mollie Brown

14. NAME OF HUSBAND OR WIFE: Garfield Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Madie Browning — Address: 5145 Palm

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Infarction — 6 mth

DUE TO (c): 420

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Jan 1. 60 to Mar 21. and last saw her/him alive on Mar 21. 60

Death occurred at 4 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Walter A. Younge (Degree or title) MD

22b. ADDRESS: 4635 Easton

22c. DATE SIGNED: 3/22/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 3/23/60

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): Austin, Texas

24. FUNERAL DIRECTOR: Charles J. Gates — ADDRESS: 4107 Finney

25. DATE RECD. BY LOCAL REG.: MAR 23 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MDB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Guyton Swan

Signature of Student Embalmer

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.