

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012588

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3247

STATE FILE NUMBER

FILED APR 6 1962

VS 300
Rev. 4/59

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RATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 53 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hsp.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4330 Cote Brillante				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VORIS DICKER SON						4. DATE OF DEATH Month Day Year March 23, 1962					
5. SEX Male		6. COLOR OR RACE Negro		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/17/09		9. AGE (last birthday) 52		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 11 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drt. Recreational Ctr.				10b. KIND OF BUSINESS OR INDUSTRY Recreation ctr.		11. BIRTHPLACE (City and state or country) Mayfield, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Roger Dickerson				13b. MOTHER'S MAIDEN NAME Emma				14. NAME OF HUSBAND OR WIFE Lina Dickerson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Lina D. Dickerson, 4330 Cote Brill.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular thrombosis <i>gk. Cerebral vascular thrombosis</i> CONDITIONS, if any, which gave rise to above cause (a) 332x DUE TO (b) DUE TO (c) 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year									
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 Sept 19 61 to March 1962 and last saw her/him alive on 7:20 am on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at											
22a. SIGNATURE JOS. W. Hoard (Degree or title) <i>Dr. Joseph W. Hoard M.D.</i>						22b. ADDRESS 5701 Concord			22c. DATE SIGNED 3-26-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/27/62		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Mo.		(State)			
24. FUNERAL DIRECTOR Charles J. Gates, Jr., 4107 Finney						ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 27 1962		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Georgette Swann

Licensed Embalmer No. 4580

P. O. Address 4107 Fenway

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.