

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-029867**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7348**

STATE FILE NUMBER

**FILED JUL 19 1963**

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>Webster Groves</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>135 Selma</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARJORIE</b> Middle <b>F.</b> Last <b>DIXON</b>			4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1963</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/13/1903</b>
9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Rolla, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Shaver</b>	
13b. MOTHER'S MAIDEN NAME <b>Ida Owens</b>		14. NAME OF HUSBAND OR WIFE <b>L. Clark Dixon</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.	17. INFORMANT Address <b>L. Clark Dixon 135 Selma Webster Groves</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Source not determined as yet</b>			
DUE TO (c) <b>199.2</b>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 <b>Nov. 1962</b> to <b>7-16-63</b> and last saw her <sup>him</sup> alive on <b>July 16 63</b> Death occurred at <b>6:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul K. Webb M.D.</b>		22b. ADDRESS <b>721 Olive St. St. Louis, MO</b>	22c. DATE SIGNED <b>7-16-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/18/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Lupton Chapel, Inc 7233 Delmar Blvd</b>		25. DATE REG. BY LOCAL REG. <b>JUL 18 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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 SHOULD READ  
 BY AFFIDAVIT OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 USE BLACK INK OR TYPEWRITER RIBBON

Dixon City

Dr. Paul K. Webb  
Chemical Bldg

2 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 \_\_\_\_\_

*Clarence H. Murray*

Licensed Embalmer No. \_\_\_\_\_

*407 P*

P. O. Address \_\_\_\_\_

*H. Lewis, 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.