MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 10581

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. ✓

Township ..... Primary Registration District No. 1003 Registered No. 3268

City St. Louis, Mo. (No. City Sanitarium St. ..... Ward)

2. FULL NAME Isabelle Dickson

(a) Residence. No. 1503 Chestnut St., 13 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Burl Dickson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Years about 66 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lawrence Co. Mississippi

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): " ✓
12. MAIDEN NAME OF MOTHER: " ✓
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): " Kentucky

14. INFORMANT (Address): Louis H. Kohler 5300 Arsenal

15. FILED APR - 1 1927 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/29/27 19

17. I HEREBY CERTIFY, That I attended deceased from 3/21/27, 19..., to 3/29/27, 19..., that I last saw her alive on 3/29/27, 19..., and that death occurred, on the date stated above, at 9:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
92A
107A
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY): Chronic Valvular Disease (Mitral Regurgitation)
(duration) ..... yrs. ..... mos. 9 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 90A
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Louis H. Kohler, M. D.
3/30/27, 19 (Address) 5300 Arsenal

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery | DATE OF BURIAL: April 2nd 1927

20. UNDERTAKER: A. L. Beal | ADDRESS: 2726 Lucas Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3268

City St. Louis (No. ....., ... St. ..... Ward)

2. FULL NAME Isabelle Dickson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	B	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ..... L-9 ....., 19 ..... Mary C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1937

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... that I last saw h..... alive on ..... 19 ..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

Unknown

S-10581