

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

Do not use this space.

42556

12323

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. 791
Primary Registration District No. 1002
arsenal

File No.....
Registered No.....
St. Hospital Ward)

2. FULL NAME

Male Dickens

(a) Residence. No. 5800 Arsenal St. Hospital Ward. 13 Chesterfield Mo
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-16-1857</u>		
7. AGE YEARS <u>78</u>	MONTHS <u>9</u>	DAYS <u>+</u>
IF LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>general farming</u> (c) Name of employer <u>himself</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>		
PARENTS	10. NAME OF FATHER <u>Hugh Dickens</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>North Carolina</u>	
	12. MAIDEN NAME OF MOTHER <u>Charlotte Hill</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-1, 1929, to 12-17, 1929, that I last saw him alive on 12-7, 1929, and that death occurred, on the date stated above, at 12:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocardia
93E

CONTRIBUTORY (SECONDARY) POB (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) Bullburn M. D.
12-18-1929 (Address) 5800 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 DATE OF BURIAL
St. Ann Cem Chesterfield Mo 12-19 1929

20. UNDERTAKER ADDRESS
Schroder Hud Co Bullburn Mo

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.

15. FILED DEC 18 1929

REGISTRAR

