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

Do not use this space.

10545

1. PLACE OF DEATH

County ..... Registration District No. 72 ..... File No. 10545

Township ..... Primary Registration District No. 2000 ..... Registered No. 2533

City St. Louis, Mo. (No. St. Anthony's Hospital St. ..... Ward)

2. FULL NAME Eleanor Dixon

(a) Residence. No. 2665-A Iowa 13 Ward. (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 5 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) |
|---|---|---|
| Female | White | Widowed |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 17, 1856

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 73 | 11 | 25 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~~Not employed~~ Hwrk

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ruma (STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Phillip Devereux

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

12. MAIDEN NAME OF MOTHER Ursula Simpson

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

14. INFORMANT Lucille Dixon (Address) 2665 A Iowa Ave

15. FILED ..... 19 Max C Harley REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-12 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Mar 12, 1930 that I last saw her alive on 3-11, 1930 and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Embolus

82B

(duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (SECONDARY) None

(duration) yrs. mos. ds.

740

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Findings etc

(Signed) Leon C. Hailes, M. D.

3/12, 1930 (Address) 1005 So. Ewing.

*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 |
|---|---|
| Red Bud, Ill | 3-14-1930 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| Grover A Dashner | Red Bud Ill |

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.