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

Do not use this space.

37932

File No. 791 1003

Registered No. 11076

**1. PLACE OF DEATH**

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City St. Louis, Mo. (No. City Hospital #2 St. ..... Ward)

**2. FULL NAME** John A Dickson

(a) Residence. No. 2220 Lucas St., 21 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 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) |
|---|---|---|
| M. | Col | Single |

5a. If Married, Widowed, or Divorced: Husband of (or) Wife of —

6. DATE OF BIRTH (Month, day and year) Unknown

| 7. AGE Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| abt 33 | — | — | |

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

9. BIRTHPLACE (City or town) (State or country): Mo.

PARENTS
10. NAME OF FATHER: Adam Dickson
11. BIRTHPLACE OF FATHER (City or town) (State or country): Mo.
12. MAIDEN NAME OF MOTHER: Malinda Steptoe
13. BIRTHPLACE OF MOTHER (City or town) (State or country): Mo.

14. INFORMANT: A. Gertrude Creath
(Address): City Hospital #2

15. Filed NOV 23 1930, 19..... Registrar: Roy C. Walker

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (Month, day and year) 11-13-1930

17. I HEREBY CERTIFY, That I attended deceased from 10-31, 1930, to 11-13, 1930, that I last saw him alive on 11-13, 1930, and that death occurred, on the date stated above, at 8:40 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23 hr. (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical-X-Ray-Lab.

(Signed) Henry C. Sauer M. D.

11-15-, 1930 (Address) City Hospital #2

*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: Jefferson Barracks — DATE OF BURIAL: 11/24 1930

20. UNDERTAKER: [illegible] — ADDRESS: 2732 Lucas

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD