No. 2
1-4-41
-17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32632

Registration District No. 184 Primary Registration District No. 200 Registrar's No. 1923

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town KOCH (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL () (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 287 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISOURI (b) County 006

(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")

(d) Street No. 1327a No. WHITTIER ST. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JESSIE DIXON

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex FEMALE

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife OTHA FLORA

6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased 6 (Month) - 20 (Day) - 16 (Year)

8. AGE: Years 25 Months 2 Days 24 If less than one day hr. min.

9. Birthplace — (City, town, or county) TENN. (State or foreign country)

10. Usual occupation HOUSEMAID

11. Industry or business

FATHER
12. Name GARNER DIXON
13. Birthplace — (City, town, or county) TENN. (State or foreign country)

MOTHER
14. Maiden name LUCY RICE
15. Birthplace — (City, town, or county) TENN (State or foreign country)

16. (a) Informant PATIENT

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-17-1941 (Month) (Day) (Year)

(c) Place: burial or cremation Blythsville, Arkansas

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) SEP 16 1941 (Date received local registrar) (b) E. G. McGarran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 14 year 1941 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from NOV. 27, 1940 to SEPT 14, 1941; that I last saw her alive on SEPT 13, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	2½ yrs
Due to	
Due to 1361	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Pulmonary Tuberculosis Intestinal Tuberculosis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Samuel S. Rancadill (M. D. or other)

Address Koch Hosp. Koch, Mo. Date signed 9/4/41

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Johnson, Registered Apprentice No. ..... working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.