DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 12 1944

Registration District No. 378

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3058

State File No. 18994

Registrar's No. 85

1. PLACE OF DEATH:
(a) County: St. Charles
(b) City or town: St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 night (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Charles
(c) City or town: St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 415 South Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William L. Dixon
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, divorced: Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: September (Month) 1 (Day) 1943 (Year)
8. AGE: Years 0 Months 8 Days 12 If less than one day hr. min.
9. Birthplace: St. Charles (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name: William, Dixon
FATHER 13. Birthplace: Tebbets (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name: Catherine Mayer
MOTHER 15. Birthplace: St. Charles (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Mrs. Catherine Dixon
(b) Address: 415 S. Main, St. Charles, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Peters Cem. St. Charles
18. (a) Signature of funeral director: H. C. Dallmeyer & Son Co.
(b) Address: 801 N. Second, St. Charles, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1944 hour 5 minute 45 A. M.
21. I hereby certify that I attended the deceased from 5-12, 1943, to 5-13, 1944; that I last saw him alive on 5-13, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Peripheral circulatory collapse	15 minutes
Due to diarrhea & vomiting ???	48 hr.
Due to Dehydration	?
Other conditions (Include pregnancy within 3 months of death): None ? Status Lymphaticus	?

Major findings: Of operations: None
Of autopsy: Complete exam, except head entirely negative

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: R. O. Hayden M.D. (M. D. or other)
Address: St. Charles, Mo. Date signed: 6-7-44

1540

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 6-9-44

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John E. Dallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles Mo

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

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

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-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 3 10 Primary Registration District No. 3058 Registrar's No. 85

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Charles

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

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

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Wm L. Dixon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years — Months 8 Days 15 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Ernst E. Paule (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 23
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

18994