

FILED JAN 13 1945

Primary Registration District No. 1003

Registrar's No. 11372

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution St. Mary's Infirmary
(If not in hospital or institution, write street number or location)

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

In this community abt 30 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ood

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

(d) Street No. 3135 Laclede
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Albert Dickens

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex Male, Color or race col

5. Color or race col

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Oct 1 1889
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12/23 day 23 year 1945 hour 2 minute 4 A.M.

21. I hereby certify that I attended the deceased from 12-23 to 12-23, 1945; that I last saw him alive on 12-22, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Several Peritonitis Duration 3 days

Due to Perforated appendix 4 days

Due to Gangrenous appendix 4 days

Other conditions Hypertrophy of prostate 2 yrs

8. AGE: Years 56 Months 2 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Garbage Collector

11. Industry or business City of St. Louis

MOTHER FATHER { 12. Name Bert Susan

13. Birthplace N.C.
(City, town, or county) (State or foreign country)

14. Maiden name Melissa Taylor

15. Birthplace N.C.
(City, town, or county) (State or foreign country)

16. (a) Informant Susie Addison

(b) Address 3135 Laclede

17. (a) Buried (b) Date thereof 12-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director R.M.C. Green

(b) Address 3517 Laclede

19. (a) DEC 26 1945 (b) J. F. Brodeck
(Date received local registrar) (Registrar's signature)

Major findings: Of operations 1/2/1

Of autopsy Several Peritonitis

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? _____ (c) Means of injury _____

23. Signature Mason D. Clark (M. D. or other) MD

Address 1536 Papineau St Date signed 12/25/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *A. M. Green*.....

Licensed Embalmer No. 1173.....

P. O. Address 3517 S. L. L. C......

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

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

Registration District No. *318*

Primary Registration District No. *1003*

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... *St. Louis*
 (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)

3. (a) PRINT FULL NAME *Albert Dickens*
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex *M* 5. Color or race *B* 6. (a) Single, widowed, married, divorced, *married*
 6. (b) Name of husband or wife *(Miss)* 6. (c) Age of husband or wife if alive *59* years
 7. Birth date of deceased *Oct 1, 1889*
 (Month) (Day) (Year)

8. AGE: Years *56* Months *2* Days *2* If less than one day
 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 12. Name.....
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 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) *JAN 17 1946* (b) *J. F. Bredeck*
 (Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
 year..... hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... to.....
 that I last saw him..... alive on.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy.....

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?
 While at work?..... (Specify type of place)
 (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

Duration
 Underline the cause to which death should be charged statistically.

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