S. No. 2
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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. 10748

FILED MAR 31 1947

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 2501

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: 4302 W. Pine Blvd.,
(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 Mo. (b) County 19000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4302 W. Pine Blvd., 9
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Dr. Charles H. Dixon.
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife May Dixon
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased Oct. 25, 1871. (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	4	14	hr. min.

9. Birthplace Baltimore, Maryland (City, town, or county) (State or foreign country)
10. Usual occupation Physician
11. Industry or business .....
FATHER
12. Name ? Dixon
13. Birthplace Maryland (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Don't Know
15. Birthplace Maryland (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. May Dixon
(b) Address 4302 W. Pine Blvd.,
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar. 12/47 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,
19. (a) MAR 10 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 9 year 1947 hour 11.00 minute A.M.
21. I hereby certify that I attended the deceased from March 8, 1947, to Same, 19..., that I last saw him alive on March 8, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to Chr. Myocarditis
Gen'l arterio sclerosis
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings:
Of operations .....
Of autopsy no

Duration

93d

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 0
23. Signature Chas F Rosenberger (M. D. or other)
Address 7745 Olive St Road Date signed 3/10/47

(Licensed Embalmer's Statement on Reverse Side)

Dr. Charles F. Rosenberger,
7745 Olive St. Road
DE. 0211,

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. Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.