

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

30822

State File No. \_\_\_\_\_

No. 300  
10.48

FILED SEP 26 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 162 PRIMARY REG. DIST. NO. 5524 Registrar's No. 66

560

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

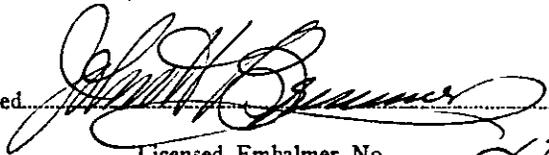
<b>1. PLACE OF DEATH</b> a. COUNTY <u>JEFFERSON</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL MERAMEC TOWNSHIP</u> c. LENGTH OF STAY (in this place) <u>6 yrs</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HILLSBORO RR#2</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>JEFFERSON</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MERAMEC TOWNSHIP</u> d. STREET ADDRESS (If rural, give location) <u>HILLSBORO RR#2 - Smith of House Spgs</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <u>SADIE</u> b. (Middle) <u>—</u> c. (Last) <u>DICKHARDT</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>SEPT-10-1949</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>DEC-11-1884</u>
<b>9. AGE</b> (In years last birthday) <u>64</u>	IF UNDER 1 YEAR <u>8</u> Months	IF UNDER 1 YEAR <u>29</u> Days	IF UNDER 1 HR. <u>—</u> Hours <u>—</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>MOORE MILL Mo</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>ALEXANDER DICKHARDT</u>	
<b>13b. MOTHER'S MAIDEN NAME</b> <u>ANNA UATZEN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>SINGLE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>A. J. Dickhardt</u>			
<b>ADDRESS</b> <u>RR#2, Hillsboro, Mo.</u>			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>	
<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebral hemorrhage</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____	
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		<u>33X</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	
<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 1st</u> , 1944, to <u>Sept 10th</u> , 1949, that I last saw the deceased alive on <u>Sept 9th</u> , 1949, and that death occurred at <u>9</u> m., from the causes and on the date stated above.			
<b>23a. SIGNATURE</b> (Degree or title) <u>V. B. Edwards M.D.</u>		<b>23b. ADDRESS</b> <u>Cedar Hill, Mo</u>	
<b>23c. DATE SIGNED</b> <u>9/12/49</u>		<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	
<b>24b. DATE</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>LOCAL CEMETERY</u>	
<b>24d. LOCATION</b> (City, town, or county) (State) <u>NEAR CEDAR HILL Mo</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. W. Summer</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>Sept 17, 49</u>		<b>REGISTER'S SIGNATURE</b> <u>Wm. W. Summer</u>	
<b>ADDRESS</b> <u>House Springs Mo</u>		_____	

District File Number \_\_\_\_\_  
District Health Officer No. 9,  
RECEIVED SEP 20 1949

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 \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed  \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_ 1470  
P. O. Address Home Springs, Mo.

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.

*[Handwritten marks and scribbles at the bottom of the page]*