No. 300
10.48

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#70204

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28127

BIRTH NO. _____ REG. DIST. NO. 818 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6993

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis,Missouri
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St.Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2199
d. STREET ADDRESS (If rural, give location) 4361 Washington Bl. 0

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES b. (Middle) E. c. (Last) DICKSON

4. DATE OF DEATH (Month) (Day) (Year) August 13th,1950

5. SEX M.
6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH abt 1875
9. AGE (In years last birthday) 75 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ireland 4
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs.Mary B.Sweeney,5935 Kingsbury Blvd.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebral Thrombosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 331X

22. *I hereby certify that I attended the deceased from* 8/7/50, 19____, *to* 8/13/50, 19____, *that I last saw the deceased alive on* 8/13/50, 19____, *and that death occurred at* 9:00am m., *from the causes and on the date stated above.*

23a. SIGNATURE Harold H. Lurie, M.D. (Degree or title)
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 8/14/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE Aug.15,1950
24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory
24d. LOCATION (City, town, or county) (State) St.Louis County,Mo.

DATE REC'D BY LOCAL REG. AUG 14 1950
REGISTRAR'S SIGNATURE J. B. Sarater
25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly
ADDRESS 3840 Lindell Blvd

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed W H Van Matre

Signed.....
Student Embalmer

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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

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