

FILED APR 12 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9885

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2881**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 11 3967 Page A	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) W. c. (Last) Dixon	4. DATE OF DEATH (Month) March (Day) 24 (Year) 1952
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 11-25-1873	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 4	IF UNDER 6 WKS. Days 4	IF UNDER 24 HRS. Hours 4	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER.	10b. KIND OF BUSINESS OR INDUSTRY CENTURY Elec.	11. BIRTHPLACE (State or foreign country) MISS.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Warner Dixon	13b. MOTHER'S MAIDEN NAME Rosetta Jackson	14. NAME OF HUSBAND OR WIFE UNKNOWN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Cornelia Giffen	ADDRESS 3967 Page
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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		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Congestion (Nontubercular) (Etiology undetermined)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 522X
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22. I hereby certify that I attended the deceased from **3-15**, 19**52**, to **3-24**, 19**52**, that I last saw the deceased alive on **3-24**, 19**52**, and that death occurred at **10:15 P** m., from the causes and on the date stated above.

23a. SIGNATURE H. K. Lewis	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier	23c. DATE SIGNED 3-25-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 3-29-52	24c. NAME OF CEMETERY OR CREMATORY FRIEDRICHS CEMETERY	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL MAR 27 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE A. F. Walton	ADDRESS 2707 Stoddard
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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 *Arthur L. Herliard*

Signed.....
Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4524 Aldene*

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.