

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43330**

FILED DEC 24 1952

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11198**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. 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 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 21 2104-a Franklin Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Toy b. (Middle) Dixon c. (Last) Carps		4. DATE OF DEATH (Month) (Day) (Year) Dec. 2 1952	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH Oct. 31, 1917
9. AGE (In years last birthday) 35		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Arkansas		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Jim Dixon		13b. MOTHER'S MAIDEN NAME Amanda ?	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Rebecca Murray- 2104-a Franklin	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix INTERVAL BETWEEN ONSET AND DEATH Undet. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Vascular Disease Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 171X		22. I hereby certify that I attended the deceased from 10-24, 1952, to 12-2, 1952, that I last saw the deceased alive on 12-2, 1952, and that death occurred at 6:25 p. m., from the causes and on the date stated above.	
23a. SIGNATURE Friederick Dickrauh, D.O.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 12-22-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Dec. 8, 1952		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE English Und. Co. - 1123 N. Taylor	
DATE REC'D BY LOCAL REG. DEC 5 1952		REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P. (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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.