

33113

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

V. S. No. 300  
Rev. 10-48

FILED SEP 24 1953

State File No. ....

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7988**

1. PLACE OF DEATH <b>St. Louis, Mo.</b> a. COUNTY <b>Missouri Pacific Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>1828 Baugh Ave. COUNTY St. Clair</b> b. CITY OR TOWN <b>Illinois</b> c. CITY OR TOWN <b>East St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>WKS</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Ms. Pac. Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>1828 Baugh Ave. 81208</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GLADYS</b> b. (Middle) <b>ALMA</b> c. (Last) <b>DOTSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 14, 1953</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>March 21, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Hickman, Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>James Oakley</b>	
13b. MOTHER'S MAIDEN NAME <b>Annie Blain</b>		14. NAME OF HUSBAND OR WIFE <b>August (Son-James)</b>	
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. <b>500-24-3679</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charles Dotson</b> ADDRESS
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Dysphylensive Ht. Dis.</b> ANTECEDENT CAUSES <b>II. Pneumonia.</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> <b>III. Malnutrition</b> II. OTHER SIGNIFICANT CONDITIONS <b>Cardiac enlargement</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) <b>443X</b>	
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?			
22. I hereby certify that I attended the deceased from <b>Aug 19 1953</b> to <b>8/19/53</b> , that I last saw the deceased alive on <b>8/14, 1953</b> , and that death occurred at <b>10:30 a. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Charles Burns M.D.</b>		23b. ADDRESS <b>1755 So Grand</b>	
23c. DATE SIGNED <b>8/15/53</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	
24b. DATE <b>August 17, 53.</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Burial Park</b>	
24d. LOCATION (City, town, or county) (State) <b>Belleville, Ill.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Burns</b> ADDRESS <b>East St Louis Ill</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>AUG 17 1953</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Burns</b> ADDRESS <b>East St Louis Ill</b>	

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

Dysphylensive Ht. Disease

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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.....  
Signature of Student Embalmer.....

*Not Embalmed*

Signed.....  
*Charles Kurnos*

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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