

FILED MAY 5 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13337

State File No.

BIRTH NO. 25009-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3606

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>St Louis</u>		c. LENGTH OF STAY (in this place) township)		c. CITY OR TOWN <u>Maplewood</u> <u>4534</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Louis Maternity</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Louis Maternity</u>		e. STREET ADDRESS <u>2007 Alameda</u>		(If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dabbs</u>			b. (Middle)			
c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>April 10 1954</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		
8. DATE OF BIRTH <u>April 10 1954</u>		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) Hours Min. <u>50</u>		
11. BIRTHPLACE (City and State or Foreign Country) <u>St Louis Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>John Taylor Dabbs</u>		13b. MOTHER'S MAIDEN NAME <u>Hazel Addine Nichols</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hazel Addine Dabbs</u>		
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) <u>Congenital Atelectasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pre Maternity - 6 months</u> DUE TO (c) <u>gestation</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>762.5</u>		
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?		
22. I hereby certify that I attended the deceased from <u>April 10 1954</u> , to <u>April 10 1954</u> , that I last saw the deceased alive on <u>April 10 1954</u> , and that death occurred at <u>3:00 P.m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE <u>John B. Orzoff</u>		23b. ADDRESS <u>79.09 634 North Grand</u>		23c. DATE SIGNED <u>4-14-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>4-30-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Carl Smith MO - Rowland - Aker 4104 Manchester</u>				
DATE REC'D BY LOCAL REG. <u>APR 21 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>		ADDRESS <u>4104 Manchester</u>		

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.....
Signature of Student Embalmer

Signed.....

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.**