

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9524

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2573

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 town(ship)) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 5 days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		STREET ADDRESS (If rural, give location) 22 939a Rutger Street 229	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) T. c. (Last) Dix			4. DATE OF DEATH (Month) (Day) (Year) March 21, 1955		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH May 4, 1893		9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		
11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME John Tribbey		13b. MOTHER'S MAIDEN NAME Rose Burch		14. NAME OF HUSBAND OR WIFE Warnie Dix	
------------------------------------	--	---	--	---	--

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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Warnie Dix - 939a Rutger Street	
--	--	------------------------------------	--	--	--

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) <u>Gastric polypoidosis Maligna</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>unknown</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>hypertension essential stroke C.U.A</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>1 yr 0 mo</u>
---	--	--	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>gastric resection total Polypoidosis</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <input checked="" type="checkbox"/>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>211x</u>	

22. I hereby certify that I attended the deceased from 1912, 1956, to 3/21, 1956, that I last saw the deceased alive on 2/21, 1956, and that death occurred at 20:00P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Chowmiller M.D.</u>		(Degree or title)		23b. ADDRESS <u>408 Humboldt</u>	
23c. DATE SIGNED <u>3/22/56</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE <u>Mar. 24, 1955</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Doe Run Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Doe Run, Missouri</u>			

DATE REC'D BY LOCAL REG. <u>MAR 22 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Helderte - 3634 Gravois Ave.</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 *Robert Wheeler*.....

Licensed Embalmer No. *212*

P. O. Address *San Francisco*

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.