

FILED JUN 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19984**  
Registrar's No. **5067**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. LENGTH OF STAY (in this place) \_\_\_\_\_

c. CITY OR TOWN **St. Louis,** d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer G. Phillips Hospital**

e. STREET ADDRESS (If rural, give location) **1222 1522 Page Blvd.** **21290**

3. NAME OF DECEASED (Type or Print)  
a. (First) **Matthew** b. (Middle) \_\_\_\_\_ c. (Last) **Dickerson**

4. DATE OF DEATH (Month) (Day) (Year)  
**June 9, 1955**

5. SEX **Male**

6. COLOR OR RACE **Negro**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Jan. 7, 1888**

9. AGE (In years last birthday) **67**  
If UNDER 1 YEAR: Months \_\_\_\_\_ Days \_\_\_\_\_  
If UNDER 24 HRS.: Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Night Watchman**

10b. KIND OF BUSINESS OR INDUSTRY **None**

11. BIRTHPLACE (City and State or Foreign Country) **Tiptonville, Tennessee**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Unknown**

13b. MOTHER'S MAIDEN NAME **Unknown**

14. NAME OF HUSBAND OR WIFE **Johinie Mae Dickerson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **Yes War I**

16. SOCIAL SECURITY NO. **492-07-9408**

17. INFORMANT'S SIGNATURE OR NAME **Johinie Mae Dickerson** ADDRESS **4522 Page Blvd.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
**Cerebral Hemorrhage**  
MEDICAL CERTIFICATION  
INTERVAL BETWEEN ONSET AND DEATH **Undt.**  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Cerebral Hemorrhage**  
ANTECEDENT CAUSES  
\*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  
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.

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **331X**

22. I hereby certify that I attended the deceased from **5-24, 1955**, to **6-9, 1955**, that I last saw the deceased alive on **6-9, 1955**, and that death occurred at **6:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Edw. B. Williams M.D.**

23b. ADDRESS **2601 N. Whittier**

23c. DATE SIGNED **6-11-55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Remove**

24b. DATE **June 13, 1955**

24c. NAME OF CEMETERY OR CREMATORY **National Cemetery**

24d. LOCATION (City, town, or county) (State) **Jefferson Barracks, Mo.**

DATE REC'D BY LOCAL REG. **JUN 11 1955**

REGISTRAR'S SIGNATURE **J. Carl Smith**

25. FUNERAL DIRECTOR'S SIGNATURE **G. Wade Granberry**

ADDRESS **4202 Finney Ave**

**14K** (Licensed Embalmer's Statement on Reverse Side)

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

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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

Signed *Melvin E. Green*.....

Licensed Embalmer No. *444*.....

P. O. Address *St. Louis*.....

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.