

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3227

FILED FEB 6 1957

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 543 Registrar's No. 74

Health, Welfare, Public Service  
300-56  
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			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, give TOWNSHIP only) OR TOWN <u>Jennings</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City 4336</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>High Towers Nursing Home</u>		Length of stay in lb <u>9 Months</u>	d. STREET ADDRESS (If outside, give location) <u>6647 Washington Blvd</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edith Norma Dickenson</u> First Middle Last			4. DATE OF DEATH <u>January 9, 1957</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 1882</u>		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>		11. BIRTHPLACE (City and state or country) <u>0 Sweetssprings, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Johnson Dickenson</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Loba</u>			15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Miss Julie Haley 6647 Washington Blvd</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Left hemiplegic old</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>April 22, 1956</u> to <u>Jan 9, 1957</u> and last saw <u>her</u> alive on <u>Jan 7, 1957</u> . Death occurred at <u>8:25 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Lewis Littmann MD</u>			22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>1/10/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>Jan. 10, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo</u>
24. FUNERAL DIRECTOR <u>Alexander &amp; Sons 6175 Delmar Blvd</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-10-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Donk MD</u>	

Dr. Filbrass  
7070202  
7-8

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 *James E. McCulloch*

Licensed Embalmer No. *2416*

P. O. Address *61708*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.