Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042505
STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2977

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Clayton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hosp. — Length of stay in 1b 8 HRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Kinloch 409 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1006 Courtney — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Baby Middle: Girl Last: Dixson

4. DATE OF DEATH Month 11 Day 11 Year 58

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 11-10-58

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 8 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Clayton, Missouri, USA.

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Lavern Dixson

13b. MOTHER'S MAIDEN NAME Ophelia Peebles

14. NAME OF HUSBAND OR WIFE NONE

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. None

17. INFORMANT St. Louis County Hospital — Address Clayton, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Atelectasis Neonatorum
DUE TO (c) 7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 11-10-58 to 11-11-58 and last saw her/him alive on 11-11-58
Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. H. Larrson, Jr. M.D. (Degree or title)

22b. ADDRESS 601 So. Brentwood

22c. DATE SIGNED 11-12-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

23b. DATE 11-17-58

23c. NAME OF CEMETERY OR CREMATORY Mt. Crematory

23d. LOCATION (City, town, or county) St. Louis (State) Mo.

24. FUNERAL DIRECTOR St. Louis County Hosp. — ADDRESS Clayton, Mo.

25. DATE RECD. BY LOCAL REG. 11-17-58

26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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.