Health, Welfare Public Service

300 -57

27/5

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002874
STATE FILE NUMBER

FILED FEB 10 1958 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 773

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN 2119 St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Chronic Hosp. — Length of stay in lb 1 mo. 19 days	d. STREET ADDRESS (If outside, give location) 3225 Montgomery — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Tom	Middle:	Last: Dix	4. DATE OF DEATH Month Day Year: 1-20-59
5. SEX: male 0	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐	8. DATE OF BIRTH: 12-20-1880
9. AGE (In years last birthday): 78	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): Unknown	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Poland 4	12. CITIZEN OF WHAT COUNTRY? Unknown
13a. FATHER'S NAME: -- Thomas Dix Sr.	13b. MOTHER'S MAIDEN NAME: -- Mary (Unknown)	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unknown	16. SOCIAL SECURITY NO.: 486-14-4689	17. INFORMANT: Angelia Stuebe	Address: 2331 Mullanphy St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Rt. Lower Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 490 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rt. Middle Cerebral Artery Thrombosis — new 2d + 19. WAS AUTOPSY PERFORMED? YES ☐ 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 12-1-58, to 1-20-59 and last saw her/him alive on 1-20-59

Death occurred at 12:10 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D. 0	22b. ADDRESS: 5800 Arsenal	22c. DATE SIGNED: 1/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 1-23-59	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri		
24. FUNERAL DIRECTOR: Cullen & Kelly	ADDRESS: 7267 Natural Bridge	25. DATE RECD. BY LOCAL REG.: JAN 23 '59
26. REGISTRAR'S SIGNATURE: J Earl Smith MD MDB		

(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 Not Embalmed, Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed James A. Lemmon, Licensed Embalmer No. 4142

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.