

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007035  
STATE FILE NUMBER  
2 1315

FILED FEB 17 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>5421 N. Kingshighway</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Alma</b> Last <b>Dickey</b>			4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1883</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Fairfield, Illinois.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Charles A. Metz</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Harper</b>		14. NAME OF HUSBAND OR WIFE <b>James T. Dickey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No. Nil.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>James T. Dickey, 5421 N. Kingshighway</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchopneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Malnutrition, Parkinson's Disease</b>					<b>years</b>
DUE TO (c) <b>Arteriosclerosis (hard) myocardial</b>					<b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I. <b>350X</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>Jan. 1956</b> to <b>Feb. 4, 1959</b> and last saw her <sup>her</sup> <b>Feb. 4</b> Death occurred at <b>11:30 am</b> on the date stated above and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John G. Hattwig M.D.</b> (Degree or title)			22b. ADDRESS <b>2807 N. Grand Blvd.</b>		22c. DATE SIGNED <b>2/6/59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Fairfield, Illinois.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 6 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

**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 *W. F. Embury* .....  
Licensed Embalmer No. *1-265* .....  
P. O. Address *4 1/2* .....

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.