

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010853

STATE FILE NUMBER

FILED MAR 25 1959 Registration District No. Primary Registration District No. Registrar's 2 2367

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospt.		d. STREET ADDRESS (If outside, give location) 4525 Beacon Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Christain M Dodson		4. DATE OF DEATH Month Day Year 3 5 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME James Dodson		13b. MOTHER'S MAIDEN NAME Mary K. Jackson	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 Address James Dodson 4525 Beacon Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <i>491X</i>			
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 <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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <i>12-15-58</i> to <i>3-5-58</i> and last saw her alive on <i>3-5-58</i> Death occurred at <i>11:00 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Clyde B. Kane M.D.</i>		22b. ADDRESS <i>706 Walton St. St. Louis</i>	22c. DATE SIGNED <i>3-6-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>3-9-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Old Mines Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Old Mines, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>J.W. Clark F.H. 1125 Hodiadmont Ave</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 7 59</i>	26. REGISTRAR'S SIGNATURE <i>Grant Smith M.D.</i>

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... *Alfred J. Buede*

Licensed Embalmer No. *266*

P. O. Address *11257 Highway*

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.