

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014588

STATE FILE NUMBER

FILED APR 29 1959

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 154

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1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Kimmswick</u> 0500 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 4</u>		Length of stay in 1b <u>4 Mo. 10 Da.</u>	d. STREET ADDRESS (If outside, give location) <u>Front & Oak Sts.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>PATRICK</u> Last <u>DIX</u>			4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1896</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>1</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Vincent Dix</u>	13b. MOTHER'S MAIDEN NAME <u>Mary McIntyre</u>	14. NAME OF HUSBAND OR WIFE <u>Ella Shanks</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>489-10-3419</u>	17. INFORMANT <u>Mrs. Ella Dix,</u> Address <u>Kimmswick, Missouri</u>
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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>Coronary Occlusion - - - - - instantaneous.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Sclerosis - - - - -</u>	<u>Unknown.</u>
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis with cerebral arteriosclerosis and peptic ulcer. 4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
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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 <u>Kimmswick</u>	COUNTY <u>Jefferson</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>Dec. 4, 1958</u> to <u>April 14, 1959</u> and last saw xxx <u>him</u> alive on <u>April 14, 1959</u> Death occurred at <u>3:50 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>John A. Brennan MD</u> (Degree or title)	22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>	22c. DATE SIGNED <u>4-14-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Festus Presbyterian Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Festus, Missouri</u>
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24. FUNERAL DIRECTOR <u>Vinyard Fun'l Homes, Inc., Festus, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Apr 21, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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