

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019103

STATE FINE NUMBER  
2 4585

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

FILED MAY 26 1959

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS. MO</u>		c. CITY OR TOWN <u>ST LOUIS. MO</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1416 R. COLE</u>		d. STREET ADDRESS (If outside, give location) <u>1416 R. COLE</u>	

3. NAME OF DECEASED (Type or print) First <u>SAM</u> Middle <u>DICKSON</u> Last			4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>59</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-1905</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ 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>LABOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS. MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
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13a. FATHER'S NAME <u>EDWARD DICKSON</u>	13b. MOTHER'S MAIDEN NAME <u>EMMA DICKSON</u>	14. NAME OF HUSBAND OR WIFE <u>_____</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>_____</u>	17. INFORMANT <u>JOHN CARTER 1414 N-18 ST</u>	Address
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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>Pulmonary Embolism (non-traumatic)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>465x</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>5/11/59</u>
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23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETRY.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO.</u>
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24. FUNERAL DIRECTOR <u>PEASTON FUNERAL 3615 EASTON</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 11 '59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u>
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B.P.

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 *Leroy W. Hamister* .....  
Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.