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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023710
State File No.

FILED JUN 22 1959

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1589

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission?) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Bellefontaine Heights</u>		c. LENGTH OF STAY (in days) <u>4 days</u>	c. CITY OR TOWN <u>Bellefontaine Heights</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Training School Bellefontaine Rd.</u>		d. Is Residence within limits of a city of incorporation? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOEL</u> b. (Middle) <u>WILLARD</u> c. (Last) <u>DIXON</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>11</u> (Year) <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-18-1946</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Poplar Bluff, MO</u>
13a. FATHER'S NAME <u>WILLARD ERASTES DIXON</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES JUNE WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>W. V. R.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records of St. Louis State Tr. School</u> ADDRESS <u>10695 Bellefontaine Rd.</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mental Deficiency, Idiopathic Epilepsy</u>		<u>Normal birth</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>491X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/8, 1959, to 6/11, 1959, that I last saw the deceased alive on June 11, 1959, and that death occurred at 10:12 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Edward P. Kruff, M.D.</u> (Degree or title)	23b. ADDRESS <u>10695 Bellefontaine Road St. Louis</u>	23c. DATE SIGNED <u>6/11/59</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>6-13-59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>
24d. LOCATION (City, town, or county) (State) <u>Campbell, Mo.</u>		

25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, Inc. ADDRESS 4700 Washington Blvd.

DATE REC'D BY LOCAL REG. 6-11-59 REGISTRAR'S SIGNATURE Jahn E. Murphy, M.D. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 26 1959

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.....
Licensed Embalmer No.....
P. O. Address.....

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.