

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026561

FILED JUL 17 1959

2 6369

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		c. CITY OR TOWN St. Louis. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2917 Cherokee		d. STREET ADDRESS (If outside, give location) 2917 Cherokee St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Lee Roy Dixon			4. DATE OF DEATH Month Day Year July 5 1959			
---	--	--	---	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-20-88	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) N. Carolina	12. CITIZEN OF WHAT COUNTRY USA.
---	-----------------------------------	--	--

13a. FATHER'S NAME Isam Dixon	13b. MOTHER'S MAIDEN NAME Stacia Dimmit	14. NAME OF HUSBAND OR WIFE Madeline Dixon
---	---	--

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. unknown	17. INFORMANT Address Mrs. Madeline Dixon 2917 Cherokee
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bronchial asthma and	
	DUE TO (c) generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ant		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.) tra
---	---	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT 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
---	--	--	---

21. I attended the deceased from 1958 to July 5 1959 and last saw her/him alive on July 5, 1959 Death occurred at 2917 Cherokee on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) J. J. Mayne M.D.	22b. ADDRESS 3512 Drake	22c. DATE SIGNED 7-6-59
---	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-8-1959	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	------------------------------	--	--

24. FUNERAL DIRECTOR'S ADDRESS Southern Funeral Home 6322 S. Grand Blvd. St. Louis Mo.	25. DATE RECD. BY LOCAL REG. JUL 6 '59	26. REGISTRAR'S SIGNATURE Leon Smith. M.D.
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Maizus.
Monday 1-4 PM.

3606, *St. Louis*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

David Van Johnson

Licensed Embalmer No. *1942*

P. O. Address *St. Louis 110*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.