

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 31 1959

59-030925

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2299 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>University City</b>		Length of stay in 1b <b>Unk</b>	c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1163 N. &amp; S. Rd.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1163 N. &amp; S. Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>S</b> Last <b>Dixon</b>			4. DATE OF DEATH Month <b>8</b> Day <b>25</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/20</b>	9. AGE (last birthday) <b>39</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Emp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store Opr.</b>		11. BIRTHPLACE (City and state or country) <b>Keyser, west Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Walter Dixon</b>		13b. MOTHER'S MAIDEN NAME <b>Eva Unk</b>		14. NAME OF HUSBAND OR WIFE <b>Juanita Dixon</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unk</b>	17. INFORMANT <b>Juanita Dixon 1163 N. &amp; S. Rd.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		<b>5 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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 <input type="checkbox"/> 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 <b>Keyser West Va.</b>	COUNTY	STATE
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21. I attended the deceased from **8/12/57** to **8/25/57** and last saw her/him alive on **Apr 1, 1959**  
Death occurred at **10:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Lincoln West</b> (Degree or title)	22b. ADDRESS <b>1506 Hodiament Ave</b>	22c. DATE SIGNED <b>8/26/59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-27-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) <b>Keyser West Va.</b>
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24. FUNERAL DIRECTOR <b>J.W. Clark F.n. 1125 Hodiament Ave.</b>	25. DATE RECD. BY LOCAL REG <b>8-26-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alfred J. Breda

Licensed Embalmer No. 266

P. O. Address 1125 Hyde

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.