

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008106-

Registration District No. XC-21040909		SL 20448		2 2365		STATE FILE NUMBER	
DEED FILED VS MAR 8 1960		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 ILLINOIS b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 36 DAYS		c. CITY OR TOWN EAST ALTON		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 404 AIRLINE DRIVE		Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First JESSE Middle V. Last DAWSON				4. DATE OF DEATH Month FEBRUARY Day 26 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 12-31-94	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) HETTICK, ILLINOIS		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME RICHARD DAWSON		13b. MOTHER'S MAIDEN NAME EMMA GARRISON		14. NAME OF HUSBAND OR WIFE MAYTIE DAWSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 323-30-4986		17. INFORMANT Address E. ASTON, ILL. MAYTIE DAWSON, 404 AIRLINE DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) MONOCETIC LEUKEMIA DUE TO (c) BRONCHOPNEUMONIA 204.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 2 YEARS 2 WEEKS	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION VAH, ST. LOUIS, MO.		COUNTY _____ STATE _____	
21. VA attended the deceased from 2-21-60 to 2-26-60 and last saw him alive on 2-26-60 Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE JACK T. STEWART (Degree or title) M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 2-26-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-29-60		23c. NAME OF CEMETERY OR CREMATORY Upper Alton Cemetery		23d. LOCATION (City, town, or county) (State) Alton, MO.	
24. FUNERAL DIRECTOR Marks Mortuary, Woodriver, Illinois.		25. DATE RECD. BY LOCAL REG. FEB 29 1960		26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ALL NOTED

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

Barbara M. Bille
Licensed Embalmer No. 4375
P.O. Address St. Louis, 23. W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with this requirement 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.