

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3169 Brantner		d. STREET ADDRESS (If outside, give location) 3169 Brantner	

3. NAME OF DECEASED (Type or print) First Fred Middle Dickson Last Dickson			4. DATE OF DEATH Month September Day 15 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1901	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Genevieve, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased	
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. Hattie Cobb 3169 Brantner		

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) apoplexy, cerebral			2 da
DUE TO (b) Hy pertensive Vascular disease			1 yr
DUE TO (c) 334x			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkinson's disease		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 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 8/17 60 to 9/15, 60 and last saw ^{her} him alive on 8/16 Death occurred at 7:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE L R Wentzel (Degree or title) M.D.		22b. ADDRESS 2726 Chateau		22c. DATE SIGNED 9/16, 60 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/21/60	23c. NAME OF CEMETERY OR CREMATORY Father-Dickson Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri	

24. FUNERAL DIRECTOR E.B. Keane	ADDRESS 1221 North Grand	25. DATE RECD. BY LOCAL REG. SEP 17 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Melvin Blackman

Licensed Embalmer No. 3962

P. O. Address 1221 N 2nd

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.