

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1087-63-008511
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED FEB 19 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 18 Yrs/		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 1927 Hickory	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE E. DAWSON		4. DATE OF DEATH Month Day Year Jan. 31, 1963	
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 8/12/16
9. AGE (last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		11. BIRTHPLACE (City and state or country) Ohio
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Seed Co.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Gladys Dawson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW2	
16. SOCIAL SECURITY NO. 280 03 9541		17. INFORMANT Gladys Bullock Dawson, 1927 Hickory	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar fracture of skull with subdural hemorrhage; Retroperitoneal Hemorrhage; Coronary artery disease, apparently suffered in fall to street on January 26, 1963. In front of about 2013 Park Avenue. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) accident 903.5		INTERVAL BETWEEN ONSET AND DEATH PART II. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) see above	
20c. TIME OF INJURY Hour a.m. p.m. 1-26-63	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Street 22		20f. CITY, TOWN, OR LOCATION St. Louis, Mo	
20g. COUNTY		20h. STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul J. Simon		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 2/1/63		22d. NAME OF CEMETERY OR CREMATORY National Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/4/63	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City; town, or county) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR McLaughlin Funeral Home, 2301 Lafayette, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. FEB 1 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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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. 4558

P. O. Address St. Louis, Mo

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.