

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025816

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

6901

STATE FILE NUMBER

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

FILED JUL 12 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
Rev. 4/59					
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10					
11					
12					
13					
SHOULD READ					
ITEM NO.					

USE BLACK INK OR TYPEWRITER RIBBON

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		Length of stay in 1b 5 Days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5866 Cates Avenue
3. NAME OF DECEASED (Type or print) First Gertrude Middle Ethel Last Dixon			4. DATE OF DEATH Month June Day 30 Year 1963
5. SEX Female	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 4-10-92
9. AGE (last birthday) 71		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) Accountant (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (City and state or country) Walnut Ridge, Ark.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Andrew J. Pryor	
13b. MOTHER'S MAIDEN NAME Mary Francis Parr		14. NAME OF HUSBAND OR WIFE Joel R. 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. _____	17. INFORMANT Address 2740 Mrs. Doris G. Farmer, N. Hanley
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cyphonephritis.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. DUE TO (b) _____ DUE TO (c) 6000			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension - Arteriosclerosis.			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)	
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 9/13/57 to 6/30/63 and last saw her/him alive on 6-30-63 . Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>D. J. Hayden M.D.</i>		(Degree or title)	22b. ADDRESS 730 Hodurmonh
22c. DATE SIGNED 7-2-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7-3-63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd.		25. DATE RECD. BY LOCAL REG. JUL 2 1963	26. REGISTRAR'S SIGNATURE <i>Moan Smith, M.D.</i>

Dr. L. F. Hayden
730 Hoddiamont
Pa 1-7201
Hrs. 1-3 Tues.

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

Albert R Thompson

Licensed Embalmer No.

4237

P. O. Address

St Louis

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.