

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

102563-041359

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 24 1963

1. PLACE OF DEATH

a. COUNTY

Mo.

b. CITY (If outside corporate limits, give TOWNSHIP only)

ST. LOUIS

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

admission)

c. CITY

OR

TOWN

ST. LOUIS

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR

INSTITUTION

3053 THOMAS ST.

Inside Limits

Yes ☐ No ☐

d. STREET

ADDRESS

3053 THOMAS ST.

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

DOROTHY

L. DAWSON

4. DATE

OF

DEATH

Month

Day

Year

10 - 11 - 63

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. Married ☐Never Married ☐Widowed ☐Divorced ☒

8. DATE OF BIRTH

8-15-24

9. AGE (last birthday)

39

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)

UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Mississippi

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

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

DAVID STEWART 3053 THOMAS ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cirrhosis of Liver

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)

5810

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.

☐ Yes ☐ No ☒ Unknown

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.

Month, Day, Year

p.m.

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

COUNTY

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

(Degree of title)

22b. ADDRESS

22c. DATE SIGNED

Paul J. Linn

City

1300 Clark

10/15/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

REMOVAL

10-18-'63

FATHER DICKSON CEM.

ST. LOUIS COUNTY MO.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

LUKE JONES

1343 N. GARRISON AVE.

OCT 15 1963

Paul Smith, M.D.

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 _____

Jefferson M. Leiden

Licensed Embalmer No. 5072

P. O. Address 4535 Wacker

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.