

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8920

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. 010)

Registration District No. 399
Primary Registration District No. 100

File No. 92
Registered No. 92
Sl. No. 92 Ward

2. FULL NAME

James Dixon
(a) Residence No. 1627 Cottage Street Ward 1
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | **4. COLOR OR RACE** Col | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Alberta Dixon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 12 1899

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
28 | 4 | 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Dargass
(STATE OR COUNTRY)

10. NAME OF FATHER John Dixon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Cash

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT James Dixon
(Address) 1627 Cottage

15. FILED 3/11 1928 M. M. Conine REGISTRAR
assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-8 1928

17. I HEREBY CERTIFY, That I attended deceased from 3-4-28, 1928, to 3-8-28, 1928, that I last saw him alive on 3-7-28, 1928, and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis chronic, far advanced,

25 A (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) None
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Xray
(Signed) H.M. Smith, M.D.
3/9 1928 (Address) Old City Hospital, KR, Mo.

*State the DISEASE CAUSING DEATH, or in Deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Genevieve Tex | **DATE OF BURIAL** 3/11 1928

20. UNDERTAKER West Appleton | ADDRESS 1600 E. 19th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

