

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

Do not use this space.

20175

1. PLACE OF DEATH

County Clay Registration District No. 197
Township Sallatin Primary Registration District No. 5276
City North Kansas City, Mo. St. _____ Ward _____

File No. _____
Registered No. 39
St. _____ Ward _____

2. FULL NAME

John Lilburn Dixon
(a) Residence No. 1219 E 21st St. _____ Ward _____
(Usual place of abode)
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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 15 - 1852

7. AGE: YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 | 2 | 26 | _____

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

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

10. NAME OF FATHER John Dixon

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

12. MAIDEN NAME OF MOTHER Mary Dean

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

14. INFORMANT Rosetta Painter
(Address) 1219 East 21st St.

15. FILED 6/11-28 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1928, to June 9th 1928, that I last saw h. live alive on June 9th 1928, and that death occurred, on the date stated above, at 4 a m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Hemorrhage
440 (duration) _____ yrs. mos. da.
CONTRIBUTORY Gastric Carcinoma
(SECONDARY) (duration) 2 yrs. 6 mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Stomach
(Signed) Prunell J. Hodge M. D.
June 11, 1928 (Address) North Kansas City 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 Liberty, Mo DATE OF BURIAL 6/19 1928

20. UNDERTAKER Morton & Co ADDRESS No. K. E. Mo

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.

DEPARTMENT RECORD

76

~~1928-⁷
 1871-¹⁸
 56-11-14
 6-24
 38~~

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Clay
Township Gallatin
City (No.)

Registration District No. 199
Primary Registration District No. 2-276

File No.
Registered No. 39
St. Ward)

2. FULL NAME John Calhoun Nixon

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 15-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 2 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED May 12 1928 R. H. Agg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him since on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D.
, 19 (Address)

*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 DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

WRITE PLAIN INK WITH UNFADING INK--THIS IS AN ENHANCED RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-20175