

FILED FEB 16 1940

Registration District No. **717**

Primary Registration District No. **9441**

1. PLACE OF DEATH:

(a) County **Pulaski**
(b) City or town **Stanna**
(c) Name of hospital or institution: **Rural Liberty**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pulaski**
(c) City or town **Stanna**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural Liberty**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

In this community _____ years, months or days

3. (a) PRINT FULL NAME **Nettie Mae Dawson**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Wade Dawson** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Aug 24 1891**
(Month) (Day) (Year)

8. AGE: Years **48** Months **4** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **Brownfield Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Daniel Hicks**

13. Birthplace **Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Francis Cook**

15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Wade Dawson**

(b) Address **Stanna Mo**

17. (a) **Burial** (b) Date thereof **Jan 20 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Triggview**

18. (a) Signature of funeral director **R. B. J. [unclear]**

(b) Address **Rickland Mo**

19. (a) **Jan 16 1940** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **18**th
year **1940** hour **1** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Feb. 14**, 19**39**, to **Jan 18**, 19**40**;
what I last saw him alive on **Nov. 18**, 19**39**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of uterus which involved the rectum**
Due to **(which involved the rectum)**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **48**

Major findings: Of operations _____

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature **C. Maltbie** (M. D. or other) _____
Address **Crosser, Mo** Date signed **1/16/40**

Duration **about 18 months**

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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.

State of Ohio
1900

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Not Embalmed
RECEIVED

District Health Officer No. 5,
District File Number 240-210
Date Filed 2/4/40

Signed RB Dupes
Licensed Embalmer No. 3198
P. O. Address Richland 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3424
Do not use this space.

1. PLACE OF DEATH

(a) County Pulaski Registration District No. 712
 (b) Township Liberty Primary Registration District No. 2941 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nettie May Dawson

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
48 4 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-18, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Jan 19, 1940 Orville C. Oliver Local Registrar.

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) C. Mallette, M. D.
crocker (Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
 OCCUPATION is very important.
 Every item of information should be carefully supplied. AGE should be stated in full.
 PHYSICIANS should state

S-3424