

FILED AUG 3 1940

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

24734

Do not use this space.

1. PLACE OF DEATH

(a) County Butler Registration District No. 89
(b) Township _____ Primary Registration District No. 3007 Registered No. _____
(c) City Poplar Bluff (d) Street No. _____
(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

(a) Residence, No. 250 Herbert Dixon St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)
25 Lois

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 21-1900
7. AGE YEARS 40 MONTHS 3 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. U.S. Navy
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 _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poplar Bluff Mo
FATHER 13. NAME Henry Clay Dixon
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape G. Mo.
MOTHER 15. MAIDEN NAME Emma Stratman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bollinger Mo
17. INFORMANT (ADDRESS) Estella Dixon
Poplar Bluff Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Alton Lawn Aug 1 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank H. Holt, Co
Poplar Bluff Mo
20. FILED Aug 5 1940 O. C. Custer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 30 1940

HEREBY CERTIFY, That I attended deceased from July 30 to July 30, 1940
I last saw him alive on July 29, 1940. Death is said to have occurred on the date stated above, at 220 P. m.
The principal cause of death and related causes of importance were as follows:

Broncho pneumonia July 30, 1940
Parkinsonian Syndrome 1919.
Date of onset

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) J. H. Creech, M. D.
(Address) Poplar Bluff, Mo

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.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24784**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **89**

Primary Registration District No. **3007**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF BIRTH:

(a) County **Butler**
(b) City or town **Poplar Bluff**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days)

3. (a) PRINT FULL NAME **Herbert Dixon**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **Div**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **apr 21 1900**
(Month) (Day) (Year)

8. AGE: Years **40** ~~37~~ Months **3** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **9/1/40** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH **July 30 1940**
month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) _____ (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) _____

Address **Poplar Bluff** Date _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

