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FILED FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1748

Registration District No. 79

Primary Registration District No. 4047

Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County Boone
(b) City or town STURGEON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution HH yrs.
In this community HH yrs.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Sturgeon
(If outside city or town limits write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME FREDRICK GLENN DIXON

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ANNIE DIXON 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased APR. - 9 - 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Polt. Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

12. Name MICHAEL DIXON

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

14. Maiden name MARTHA HALE

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

16. (a) Informant Gracie Soman

(b) Address Sturgeon, Mo.

17. (a) BURIAL (b) Date thereof Jan. - 23 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. HOPE

18. (a) Signature of funeral director Barnes & Booth

(b) Address Sturgeon, Mo.

19. (a) Jan. 23-41 (b) Booth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1941 hour 3 minute 45 P M.

21. I hereby certify that I attended the deceased from Jan 16
1941, to Jan 21, 1941;
that I last saw him alive on Jan 21, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 5 days
Due to Pneustitis - with lobules
Drainage - pneumonia 10 days
Due to infection of lungs

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
 Of autopsy

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

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 W. M. Lewis M.D. or other D
Address Sturgeon Mo Date signed 1-23-41

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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 *P. E. Booth*

Licensed Embalmer No. *4087*

P. O. Address *Sturgeon, 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.

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

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Sturgeon
(If outside city or town limits, write "RURAL" and name of township)

(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 _____ years, months or days

3. (a) PRINT FULL NAME Frederick Glenn 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 m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 74 Months 9 Days 12

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 _____ (City, town, or county) _____ (State or foreign country)

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) _____ (b) _____

(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: Month Jan day 21 year _____ hour _____ minute _____ M.

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

Immediate cause of death Bronchitis
Prostatitis with Cateter drainage ascending infection
Chr. Nephritis

Other conditions _____ (Include pregnancy within 6 months of death)

Major findings: Of operations _____ 131 R

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 A. P. McComas (M. D. or other) _____

Address Sturgeon Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-1748