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FILED MAR 10 1944

Primary Registration District No. **4456**

Registrar's No. **4**

1. PLACE OF DEATH:

(a) County **ST. CLAIR**
(b) City or town **APPLETON CITY**
(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 **60 yrs.** (Specify whether
In this community **60 yrs.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **ST. CLAIR**
(c) City or town **APPLETON CITY, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

3. (a) PRINT FULL NAME **MARY EFFIE DIXON**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **10**
year **1944** hour minute **2 30** M.
21. I hereby certify that I attended the deceased from **January 25**
1944 to **Feb 10**, 19**44**
that I last saw him alive on **Feb 10**, 19**44**
and that death occurred on the date and hour stated above.

4. Sex **7** 5. Color or race **W**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased **Apr 9 1869**
(Month) (Day) (Year)

Immediate cause of death
Pneumonia
Embolus in left femoral
artery
Cancer of uterus
Due to

8. AGE: Years **74** Months **10** Days **1**
If less than one day hr. min.
9. Birthplace **PIKE Co Mo**
(City, town, or county) (State or foreign country)

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.

MOTHER FATHER
11. Industry or business
12. Name **John Haase**
13. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary White**
15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

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?

16. (a) Informant **Mrs E B Dixon**
(b) Address **Appleton City Mo 93**
17. (a) **BURIAL** (b) Date thereof **2 18 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Pleasant Grove Cem.**
18. (a) Signature of funeral director **Osceola K. KOFF**
(b) Address **Appleton City Mo**
19. (a) **February 12 1944** (b) **Gene W. Wells**
(Date received local Registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury **0**
23. Signature **R. L. Haase** (M. D. or other) **mo**
Address **Appleton City** Date signed **2-12-44**

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

1358

RECEIVED
District Health Officer No. 7,
District File Number 2-44-299
Date Filed 3-9-44

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.....

Osborn Eckhoff

Licensed Embalmer No. 3942

P. O. Address Appleton Ct, New

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, fact should be so stated above.

Registration District No. 311 Primary Registration District No. 445-6

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Appleton city
(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 Mary Effie Dixon
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex J 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Apr 1906
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days _____ Unless than one day _____ min.

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

10. Usual occupation Housewife

11. Industry or business Housekeeping

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

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Jona W. Kelly
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb Day 10 Year 1944 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

well