

7. S. No. 2
 00M-5-43
 Rev. 5-17-39
 X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **4798**

FILED FEB 17 1947
 Registration District No. **109**

Primary Registration District No. **1002**

Registrar's No. **568**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 3545 So Benton
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community 1 month
years, months or days

3. (a) PRINT FULL NAME Louisa J. Dickson
3. (b) If veteran, name was no
3. (c) Social Security No. 22

4. Sex fe | **5. Color or** wh | **6. (a) Single, widowed, married,**
1 | **race** wh | **2** divorced widow
(b) Name of husband or wife James Dickson | **6. (c) Age of husband or wife if**
James Dickson | alive _____ years
7. Birth date of deceased Feb -28-1860
(Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 28
If less than one day
 hr. _____ min. _____

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

10. Usual occupation House Keeper

MOTHER FATHER

11. Industry or business _____
12. Name Zephania Atterberry
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Josephine Doney
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Tralley B. Cox
(b) Address 3545 So Benton

17. (a) Removal _____ **(b) Date thereof** Feb 7-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Shelbina Mo

18. (a) Signature of funeral director Mrs. L. L. Foister
(b) Address Kansas City, Mo

19. (a) 2-7-47 **(b) Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Shelby
 (c) City or town Shelbina Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6
 year 1947 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from
Jan 29, 1947 to Feb 6, 1947
 that I last saw her alive on Feb 6, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 day
 Due to Arterio-sclerosis

Due to _____
 Other conditions Chronic myocardial degeneration
(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?

(Specify type of place)
 While at work? _____ (e) Means of injury _____
23. Signature Robert Jansen (M. D. or other) M.D.
 Address 2220 E 3rd Date signed 2-7-47

2220-3-3/-

~~Do not call for~~
~~the body~~
Do not call for
the body

Jan 18/18

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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address 918 Brooklyn
N. C., Md.

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.