No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16884

Registration District No. 72 Primary Registration District No. 5289 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Rural, Route #8, N.K.C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None, Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether

In this community 31 years years, months or days)

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County Clay

(c) City or town RR#8, N.K.C., Mo. (If outside city or town limits, write "RURAL")

(d) Street No. RR#8 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME SELMA AUGUSTA DIXON

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Penro Minor Dixon

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased Feb. 23 1875 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
72	3	11	X hr. X min.

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

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name S. P. Levine

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

MOTHER

14. Maiden name Mathilda Levine

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

16. (a) Informant Mrs. Alice McLane

(b) Address RR#8, North Kans. City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/47 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriha, K.C., Mo

18. (a) Signature of funeral director Morton-Smith's F.H.

(b) Address 832 Armour Rd., N.K.C. Mo

19. (a) June 9, 47 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1947 hour 11:35 A.M. M.

21. I hereby certify that I attended the deceased from May 15 1947, to June 6 1947, that I last saw her alive on June 6 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
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? (Specify type of place)

While at work (e) Means of injury

23. Signature Selma Dixon M.D. or other

Address Date signed 6-2-47

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 45

Registration District No. 72 Primary Registration District No. 3013

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Selma A. Dixon
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: wd
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Feb 23 1875 (Month) (Day) (Year)
8. AGE: Years 72 Months 3 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Kansas (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) June 4 47 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

16884