Parker

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

PLACE OF DEATH

County: Jasper

Township / or Village / or City: Carthage (No. 923 E. Sixth St.; Ward)

Registration District No. 408 — Primary Registration District No. 3020

File No. 35384 — Registered No. 213

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ines Dickson

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	Black	Single

DATE OF BIRTH: April 22, 1916 (Month) (Day) (Year)

AGE: 1 yrs. 5 mos. 29 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Child

BIRTHPLACE (City or town, State or foreign country): Carthage Mo.

PARENTS
- NAME OF FATHER: H. Dickson
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Bentonville, Ark.
- MAIDEN NAME OF MOTHER: Bessie Brown
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Carthage, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Dickson

(ADDRESS) Carthage Mo.

Filed Oct 22, 1917. C. Taylor, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 21 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 20, 1917, to Oct 21, 1917, that I last saw her alive on Oct 20, 1917, and that death occurred, on the date stated above, at 4:35 P.m.

The CAUSE OF DEATH* was as follows:

1. Acute Bronchitis

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory (Secondary): Whooping Cough.

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) [illegible] M. D.

Oct 22, 1917 (Address) Railroad Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct 23, 1917

UNDERTAKER: Knell Und. Co. — ADDRESS: Carthage Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191.....; and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS