MAR 23 1927

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

Do not use this space.

613

1. PLACE OF DEATH
County Dallas
Township S. Benton
City Buffalo
Registration District No. 241
Primary Registration District No. 5334
File No.
Registered No. 229
(No. ..... St. ..... Ward)

2. FULL NAME Geo. S Dimmick
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Belle Dimmick

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/22/1858

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
68	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER Oliver Dimmick
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ind.
12. MAIDEN NAME OF MOTHER Stanley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ind.

14. INFORMANT Chas. Dimmick
(Address) Louisburg, Mo.

15. FILED 3/10 1927 Harvey Morris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/28 1927

17. I HEREBY CERTIFY, That I attended deceased from 1/20, 1927, to 1/28, 1927 that I last saw ~~he~~ alive on 1/27, 1927, and that death occurred, on the date stated above, at 12 - 5 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
11A
108
11A
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At place of death
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual
(Signed) G. C. Plummer, M. D
, 19 (Address) Buffalo, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Macedonia
DATE OF BURIAL: 1/30 1927

20. UNDERTAKER: Routh & Jones
ADDRESS: Buffalo, Mo.

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.