

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

Do not use this space.

34075

1928

1. PLACE OF DEATH
 County Macon Registration District No. 533
 Township Rudson Primary Registration District No. 5713
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME James Wyley Dixon
 (a) Residence _____ 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

2. SEX Male 4. COLOR OR RACE White 5. SINGLE ~~MARRIED~~ WIDOWED OR DIVORCED Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 16 - 1844

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>83</u>	<u>2</u>			

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

9. BIRTHPLACE (CITY OR TOWN) Union Co. Ky
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Dixon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ky

14. INFORMANT F. L. Dixon
 (Address) New Cambridge Mo

15. FILED 11/21, 1927 Mrs. Luke Hunkle
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/16 19 27

17. I HEREBY CERTIFY, That I attended deceased from Mon 7, 1927, to Mon 16, 1927, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 9-45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
urinary emphysema
131
132 B
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic nephritis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) A. M. Rennie, M. D.
 , 1927 (Address) Macon 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 Berlin Mo DATE OF BURIAL 11/17 19 27

20. UNDERTAKER Albert Skinn ADDRESS Macon, Mo.

E. 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.

