

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

Do not use this space.

17833

**1. PLACE OF DEATH**

County Franklin  
Township Kawlester  
City St. Louis

Registration District No. 393  
Primary Registration District No. 6550

File No. \_\_\_\_\_  
Registered No. 7 Ward \_\_\_\_\_

**2. FULL NAME**

Clyde Sebastian Dickson

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3. SEX</b> <u>male</u>	<b>4. COLOR OR RACE</b> <u>white</u>	<b>5. SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (write the word) <u>single</u>		
<b>5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF</b> _____				
<b>6. DATE OF BIRTH (MONTH, DAY AND YEAR)</b> <u>April 16 1931</u>				
<b>7. AGE</b>	<b>YEARS</b> <u>—</u>	<b>MONTHS</b> <u>+</u>	<b>DAYS</b> <u>5</u>	<b>IF LESS than 1 day, _____ hrs. or _____ min.</b>
<b>8. OCCUPATION OF DECEASED</b>				
(a) Trade, profession, or particular kind of work _____				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** May 21 1931

**17.** I HEREBY CERTIFY, That I attended deceased from May 18 1931, to May 18 1931, that I last saw him alive on May 18 1931, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Intestinal obstruction  
12 2 1/2 B 119 B  
(duration) yrs. mos. 14 da.  
**CONTRIBUTORY (SECONDARY)** Defector of Bowel  
(duration) yrs. mos. 14 da.

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Shepard Mo. Franklin County

**10. NAME OF FATHER** Harry Dickson

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Missouri

**12. MAIDEN NAME OF MOTHER** Rosie King

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Washington Co. Mo.

**18. WHERE WAS DISEASE CONTRACTED** at home (1)

**DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** Physicid Exam  
(Signed) E. J. Harrison M. D.  
, 19 \_\_\_\_\_ (Address) Belleview 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.

**14. INFORMANT (Address)** Charles King  
Shepard Mo.

**15. FILED** July 15 1931 Belleview REGISTRAR

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Shepard Missouri **DATE OF BURIAL** May 27 1931

**20. UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

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.

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

JUL 25 1931

