

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.

JUL 22 1935

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

Do not use this space.

19634

1. PLACE OF DEATH

County Jackson Registration District No. 1003  
 Township Kaw Primary Registration District No. \_\_\_\_\_  
 City Kansas City (No. 3907 East 19th St.) St. 8553 Ward)

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2. FULL NAME Mrs. Mary Dixon

(a) Residence, No. 3907 East 19th St. 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Frank Dixon</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 4 1866</u>		
7. AGE	YEARS <u>68</u>	MONTHS <u>7</u>
	DAYS <u>27</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>At Home</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 1 1935 .19  
 22. I HEREBY CERTIFY, That I attended deceased from May 1, 1935 to June 1, 1935  
 I last saw him alive on June 1, 1935 Death is said to have occurred on the date stated above, at 10:30 A M  
 The principal cause of death and related causes of importance were as follows:

Coronary Sclerosis Date of onset \_\_\_\_\_  
Intermittent angina pectoris  
Chronic  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Autopsy Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) Dr. Frank E. Ray, M. D.  
 (Address) 4316 E 9th St.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Amboy, Illinois</u>
	13. NAME <u>Joseph J Carr</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>
	15. MAIDEN NAME <u>Mary A</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>
17. INFORMANT (ADDRESS) <u>Mrs Kathryn McDonald</u> <u>3907 East 19th St</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>_____</u> DATE <u>June 3 1935</u>	
19. UNDERTAKER (ADDRESS) <u>Quirk &amp; Tobin Co.</u> <u>20 West Linwood</u>	
20. FILED <u>6-2 1935</u> <u>M. M. Crowl</u> Registrar.	

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