

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.

OCT 2 2 1935

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

Do not use this space.

29484
3495

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City, Mo. (No. 3664 Jefferson St. _____ Ward _____)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Mrs. Mary Louise Dickenson

(a) Residence, No. 3664 Jefferson 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 F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Griffith Dickenson		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15, 1851		
7. AGE YEARS 83	MONTHS 9	DAYS 21
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Md.		
13. NAME Samuel Brotemarkle		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Md.		
15. MAIDEN NAME Elizabeth Folch		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Md.		
17. INFORMANT Mrs. Frank Burton, (ADDRESS) 500 Kensington, K.C. Mo.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Sept. 9-35		
19. UNDERTAKER C. H. Blackman & Son, Inc. (ADDRESS) 2825 Indep. Blvd. K.C. Mo.		
20. FILED 9-7 19 35 m m Crowder Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 6-35** 19 **35**

22. I HEREBY CERTIFY, That I attended deceased from **Aug 21** 19 **35** to **9-6** 19 **35**
I last saw him alive on **8-28** 19 **35** Death is said to have occurred on the date stated above, at **2:30** p. m.
The principal cause of death and related causes of importance were as follows:
Hypostatic Pneumonia (Bronch)
Date of onset **10-2**

Other contributory causes of importance:
Fractured Rt hip

Name of operation _____ Date of _____
What test confirmed _____ Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **acc** Date of injury **9-23** 19 **35**
Where did injury occur? **K.C. Mo**
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **Fell while walking**
Nature of injury **Fractured rt hip**

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____
(Signed) **W. F. Friel** M. D.
(Address) **Kansas City Mo**

