

1938 OCT 7

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

32439
Do not use this space.

1. PLACE OF DEATH *V*
(a) County *Jasper* Registration District No. *408*
(b) Township *1* Primary Registration District No. *3020* Registered No. _____
(c) City *Carthage* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred *20* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da. _____
2. PRINT FULL NAME *Mary Katherine Dixon*
(a) Residence, No. *1921 S. Main* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Thomas Dixon*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May - 1857*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 5 -
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *at home*
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 30 1938*
22. I HEREBY CERTIFY, That I attended deceased from *May 19 1938* to *Sept 30 1938*
I last saw her alive on *Sept 30 1938* Death is said to have occurred on the date stated above, at *7:20 P.M.*
The principal cause of death and related causes of importance were as follows:

Chronic Nephritis
Date of onset *(?)*
31

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *West phalia Missouri*

Other contributory causes of importance:
Senility Cerebral arteriosclerosis with mental deterioration

FATHER 13. NAME *John Williams*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

Name of operation *none* Date of _____
What test confirmed diagnosis? *physical* (Was there an autopsy?) *no*

MOTHER 15. MAIDEN NAME *Unknown*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *no* 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.

17. INFORMANT (ADDRESS) *Mrs. Charles H. Hialer 1921 S. Main Carthage*
18. BURIAL, CREMATION, OR REMOVAL PLACE *West Cemetery* DATE *Oct. 3 1938*

Manner of injury *U*
Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS) *Kneel Mortuary Carthage Mo.*

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____
(Signed) *George H. Wood*, M. D.
86 (Address) *Carthage Mo*

20. FILED *Sept 30 1938* *E. J. McEntire, M.D.* Local Registrar.

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.

RECEIVED

District Health Officer No. 6,

District File Number 6-38-263

Date Filed 10-5-38

STATEMENT BY LICENSED EMBALMER

I, Lucy Kree-Buckwell, Licensed Embalmer No. 2510

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Lucy Kree-Buckwell
Licensed Embalmer No. 2510

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)