

MAY 10 1939

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

16301
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 836
 (b) Township _____ Primary Registration District No. 45-07 Registered No. 13
 (c) City _____ or _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Minor Dickinson
 (a) Residence, No. Bernie Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Loda Dickinson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 30 - 1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 61 0 28
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Contractor.
 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) April 27, 1938
 22. I HEREBY CERTIFY, That I attended deceased from 4-27-1938 to 4-27-1938
 I last saw him alive on 4-26-1938. Death is said to have occurred on the date stated above, at 12:25 p. m.
 The principal cause of death and related causes of importance were as follows:

Coronary Stenosis Date of onset hair
946
 Other contributory causes of importance: Arteriosclerosis hair
any.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) H. S. Bond, M. D.
 _____ (Address) Bernie, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

FATHER 13. NAME Geo. Dickinson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER 15. MAIDEN NAME Mary Goodenow

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT (ADDRESS) Wife Mrs. Dickinson
Bernie Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bernie Mo. DATE April 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Landon & Son
Lyonsville, Mo.

20. FILED 5-1 1939 Laura Hopkins
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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.