

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.

NOV 14 1939

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

34971
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kaw Primary Registration District No. 1002

(c) City Kansas City (d) Street No. 213 West Armour 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 Franklin Pierce Dickson

(a) Residence, No. 213 West Armour 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

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 Mrs. Emily A. Dickson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 31, 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

86 10 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as Real Estate lawyer, bookkeeper, etc.

9. Industry or business in which work was done, as Real Estate saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rolling Prairie, Ind.

FATHER 13. NAME Daniel M. Dickson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ripley, N. Y.

MOTHER 15. MAIDEN NAME Mary Ann McHenry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Westfield, N. Y.

17. INFORMANT (ADDRESS) Mrs. Emily A. Dickson
213 W. Armour

18. BURIAL, CREMATION, OR REMOVAL PLACE Elmwood DATE Oct 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner
Kansas City, Mo.

20. FILED 10-15 19 39 mmc
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1939, to Oct. 12, 1939

I last saw him alive on Oct. 11, 1939. Death is said to have occurred on the date stated above, at 1:30 m. AM

The principal cause of death and related causes of importance were as follows:

Ends cardiac's substance

Date of onset

Other contributory causes of importance: Senility

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

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? No

If so, specify

(Signed) J. M. Coleman, M. D.
(Address) 3850 Brookway

7-1-53

774 6493

3952 B... ..

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 A R Haunschild

Licensed Embalmer No. 4062

P. O. Address K. C. Mo.

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.