

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 017

Primary Registration District No. 1862

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Pennsacola

(b) City or town near Caruthersville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Cara Regina Dickson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9-16-39
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 8 If less than one day _____ hr. min.

9. Birthplace near Caruthersville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name James O. Dickson

13. Birthplace Warders
(City, town, or county) (State or foreign country)

14. Maiden name Therese White

15. Birthplace Postageville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James O. Dickson

(b) Address Caruthersville Mo

17. (a) Postageville (b) Date thereof Oct 25, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Postageville Mo

18. (a) Signature of funeral director R. M. Payne

(b) Address Postageville Mo

19. (a) Oct 25, 1939 (b) Ada Martin 58
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: _____

(a) State Mo (b) County Pennsacola

(c) City or town near Caruthersville
(If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1939 hour 1 minute 50 PM

21. I hereby certify that I attended the deceased from Oct 20
1939 to Oct 24, 1939
that I last saw her alive on Oct 24, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Calitis Duration 10 days

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. Cair (M. D. or other) _____
Address Caruthersville Mo Date signed Oct 25, 1939

1129-635
Date Filed
District File Number 11/7/39
Inspector Health Officer No. 3
RECORDED

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.