

FILED SEP 17 1940  
Registration District No. **3990**

Primary Registration District No. **1002**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2928 Prospect 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 40 years 557  
years, months or days

3. (a) PRINT FULL NAME MATTIE RICE DICKINSON

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

4. Sex Fl 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Otis B. Dickinson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 2 1862  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Grand Haven Mich  
(City, town, or county) (State or foreign country)

10. Usual occupation H W

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James Rice

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

14. Maiden name Margaret Vandant

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

16. (a) Informant John Dickinson

(b) Address 2928 Prospect

17. (a) Burial (b) Date thereof Aug 19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wt. Washington

18. (a) Signature of funeral director Morton F. ...

(b) Address 101 ...

19. (a) Aug. 18, 1940 (b) M. H. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town \_\_\_\_\_ (If outside city or town limit, write "RURAL")  
(d) Street No. 2928 Prospect (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month August day 16 year 1940 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from Aug 3, 1940 to Aug 16, 1940 that I last saw or alive on Aug 16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia

Due to suicide

Due to 107

Other conditions (Include pregnancy within 3 months of death)

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 Dugene A. Gould (M. D. or other) \_\_\_\_\_  
Address 3506 ... Date signed 8/16/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.**