

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36499**
Registrar's No. **165**

Registration District No. **796**

Primary Registration District No. **6039**

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Rural
(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 3
Life (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 65 highway
(If rural, give location)
(e) If foreign born, how long in U. S. A.: Life years.

3. (a) PRINT FULL NAME Sarah Prudence 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 single

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

7. Birth date of deceased Sept. 10 1848
(Month) (Day) (Year)

8. AGE: Years 92 Months 1 Days 11 If less than one day
hr. _____ min. _____

9. Birthplace Paris Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name George Dickson

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

14. Maiden name Sarah Simpson
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Bessie Powell

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof Oct. 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock

18. (a) Signature of funeral director Don Short

(b) Address Marshall, Missouri

19. (a) 11-3-40 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 40 hour 3 minute 22 P M.

21. I hereby certify that I attended the deceased from Jan 10 1940 to Oct 28 1940
and that death occurred on the date and hour stated above.
that I last saw her ex alive on Oct 28 1940

Immediate cause of death Atherosclerosis Duration 3y.

Due to _____

Due to _____

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or other) _____

Address Marshall, Mo Date signed 10/27/40

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

Rev. 5-17-39
1 X 10811

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. 8,
Date Filed 11-13-40

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.....

Don Short....., Registered Apprentice No.....
working under my personal supervision.

Signed *Donald W Short*
Licensed Embalmer No. *37 57*
P. O. Address *Marshall 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.