

11-10-39
5-17-39
I X21492

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

NOV 25 1948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36530

Registration District No. 823 Primary Registration District No. 60176 State File No. _____ Registrar's No. _____

1. PLACE OF DEATH
(a) County Shannon
(b) City or town Pratts
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Bern Franklin Dixon
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 22-40
(Month) (Day) (Year)

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

9. Birthplace MO-0
(City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

MOTHER FATHER { 12. Name Charles Dixon
18. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name Irene Williams
15. Birthplace MO
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Dixon
(b) Address Evans MO

17. (a) Rural (b) Date thereof 10-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Chapel

18. (a) Signature of funeral director [Signature]
(b) Address _____

19. (a) 10-28-40 (b) Frank Keyce
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Shannon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 25-1940
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 24-40
Oct 25 1940, to _____ 1940;
that I last saw him alive on Oct Sept 25 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Bronchi)
primary

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 Frank Keyce (M. D. or other) _____
Address Evans MO Date signed 10-25-40

RECEIVED

District Health Officer No. 5,

District File Number 11401146

Date Filed _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 365-30

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 822

Primary Registration District No. 6076

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Eminence, T.P.
(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 _____
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Bern Franklin Dixon

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

4. Sex m 5. Color or race w 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: (Month) _____ (Day) _____ (Year) _____

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

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-23-40 (b) Frank Hyde M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1940 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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 Frank Hyde (M. D. or other) _____

Address Eminence, Mo. _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

