

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 2

Primary Registration District No. 205

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town SAVANNAH  
(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 60 yrs years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Andrew

(c) City or town SAVANNAH  
(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 SALLIE ALICE DICKSON

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. none

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

6. (b) Name of husband or wife J. N. S. DICKSON 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 9-29-1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24  
year 1940 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from November 18, 1940, to November 24, 1940  
that I last saw her alive on Nov 22, 1940  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>1</u>	<u>25</u>	hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Arterio Sclerosis

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation At home

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

MOTHER FATHER

12. Name WILLIAM BOHART

13. Birthplace MORGAN CO IND  
(City, town, or county) (State or foreign country)

14. Maiden name MARY BURNS

15. Birthplace MORGAN CO IND  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature E. B. Sparks

(b) Address SAVANNAH MO

17. (a) B (Burial, cremation, or removal) (b) Date thereof 11-26-1940  
(Month) (Day) (Year)

(c) Place: burial or cremation SAVANNAH MO

18. (a) Signature of funeral director E. B. Breit

(b) Address SAVANNAH MO

19. (a) Nov 26-40 (Date received local registrar) (b) Mrs. Jennie Raab (Registrar's signature)

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? at home

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. B. Kelley (M. D. or other) MD

Address Savannah Date signed 11-28-40

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.

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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 E. C. Breit

Licensed Embalmer No. 2658

P. O. Address. Savannah ms

**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.**