No. 2
1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAR 14 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5919

Primary Registration District No. 1002

Registrar's No. 691

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution:
K.C. General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution two days (Specify whether years, months or days)

In this community 20 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4305 East 15th St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME W.L. Dix (William L. Dix)

3. (b) If veteran, name war: No

3. (c) Social Security No. None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Rachel Dix

6. (c) Age of husband or wife if alive: 72 years

7. Birth date of deceased: May (Month) 10 (Day) 1865 (Year)

8. AGE: Years 75 Months 7 Days 5 If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Rachel Dix
(b) Address: 4305 E. 15th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 18 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill

18. (a) Signature of funeral director: Rose & Henderson
(b) Address: Kansas City, Missouri

19. (a) Feb. 17, 1941 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15th year 1941 hour 9 minute 05 A.M.

21. I hereby certify that I attended the deceased from 2-13-41, 19..., to 2-15-41, 19...; that I last saw him alive on 2-15-41, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intracerebral hemorrhage left	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:

Of autopsy: See above

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

23. Signature: Henry R. Thorne (M.D. or other)
Address: Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 G. C. Henderson

Licensed Embalmer No. 3657

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.