

DEC 22 1941  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4178

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:  
12105 Prospect  
(If not in hospital institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 years  
(Specify whether years, months or days)  
In this community 8 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. 2105 Prospect  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Dixon

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security 496-05-8088

4. Sex Male 5. Color or Colored  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Madge Dixon  
6. (c) Age of husband or wife if alive 44 years  
7. Birth date of deceased May 1st 1896  
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 3  
If less than one day hr. min.

9. Birthplace Hope Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Gabor

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

12. Name Allen Dixon

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

14. Maiden name Temple Johnson

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

16. (a) Informant Mrs Madge Dixon

(b) Address 2105 Prospect

17. (a) Burial (b) Date thereof 11-12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director J. A. Moore

(b) Address 1820 E-18th St

19. (a) 11-11-41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4  
year 1941 hour 8:20 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to Cerebral thrombosis  
Due to Cerebral thrombosis

Other conditions (Include pregnancy within 3 months of death) 94a

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) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature Russell W. Crowe (M. D. or other) \_\_\_\_\_  
Address FCM Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Mc

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 *me*

*H B Mann*, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *H B Mann*

Licensed Embalmer No. *2410*

P. O. Address *1820 E 18th*

**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, fact should be so stated above.**