

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18095
Do not use this space.

FILED JUN 15 1942

1. PLACE OF DEATH
(a) County Howard, Registration District No. 378
(b) Township _____ Primary Registration District No. 4222 Registered No. 28
(c) City Fayette, (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. _____
Mrs Anna Dickerson, ✓

2. PRINT FULL NAME
(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female / 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR Widowed (Use word) 2

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF William O, Dickerson, (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 10th 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 0 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home.
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky, /

FATHER 13. NAME Silas Buford,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky, /

MOTHER 15. MAIDEN NAME Mary Doyle,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky, /

17. INFORMANT Mrs Jake Eaton, (ADDRESS) Fayette, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Harrisburg, DATE 5-4th 1942

19. FUNERAL DIRECTOR (NAME) Guy T. Halley. (ADDRESS) Fayette, Mo.

20. FILED 5-4 19. 42 Thomas B. Denny Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2nd 1942

22. I HEREBY CERTIFY, That I attended deceased from April 29th 1942 to May 2nd 1942. I last saw h. & c. alive on May 2nd 1942. Death is said to have occurred on the date stated above, at 120 p. m.
The principal cause of death and related causes of importance were as follows:
Perforated Ulcer-pylorus - 4-28-42
1170
Generalized peritonitis -

Other contributory causes of importance: _____

Name of operation Laparotomy Date of 4-30-42
What test confirmed diagnosis? Exam Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) W. Reagh M.D. M. D.
(Address) Res Hospital, Fayette, Mo.

RECEIVED.

District Health Officer No. 8,

District File Number _____

Date Filed 6-12-42

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 Guy T. Hallen

Licensed Embalmer No. 2966

P. O. Address Jayells 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.

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Frayette
(If outside city or town limits, state "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, years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Slickerson

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased 09 10 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months - Days 12 (If less than one day) min.

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

10. Usual occupation

11. Industry of 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-9-42 (b) Thomas S. Dewey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 12 year 1942 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from 9 to 6 1942; 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)

PHYSICIAN

Major findings:
Of operations

Of autopsy

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 (M. D. or other) Address Date signed

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

SUPPLEMENTARY

