

1. PLACE OF DEATH:

(a) County CARROLL
 (b) City or town CARROLLTON
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
117. 7th Main St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 65 yrs
 years, months or days

3. (a) PRINT FULL NAME MARGUERITE M. DICKSON

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Charles Dickson 6. (c) Age of husband or wife if alive Deceased years
 7. Birth date of deceased 7/11 12 1867
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 8 19 hr. min.

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

10. Usual occupation Home wife

11. Industry or business _____

MOTHER FATHER { 12. Name Anna Rose
 13. Birthplace Zinscohen 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah J. Anderson
 15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Adams

(b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof 8-2-42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Zellie Marshall

(b) Address Carrollton Mo.

19. (a) 8-1-1942 (b) Mrs. James Rafferty
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Carroll
 (c) City or town Carrollton
 (If outside city or town limits, write "RURAL")
 (d) Street No. 117. 7th Main St.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1st
 year 1942 hour 12 minute 5 A.M.

21. I hereby certify that I attended the deceased from 5-30-42
 _____, 19____, to Aug 1st, 1942

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis
Cardiac Insufficiency
Carbuncles of Face
 Due to _____

Duration
?
?
?

Due to _____

Other conditions _____
 (Include pregnancy within 5 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 William G. Atwood (M. D. or other)
 Address Carrollton Mo Date signed 8/4/42

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

17
/

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-13-42

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 myself

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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, fact should be so stated above.