

FILED MAY 1 5 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 5227

1. PLACE OF DEATH

(a) County Crawford Missouri

(b) City or town Rural

(c) Name of hospital or institution Near Keyville Mo  
(If outside city or town limits, write "RURAL" and name of town)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 5 years

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

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

(d) Street No. Near Keyville Mo  
(If rural, give location)

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

3. (a) PRINT FULL NAME Jamima Catherine Dickson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 28<sup>th</sup> year 1943 hour 3 minute 9 M.

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

6. (b) Name of husband or wife James Dickson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
Birth date of deceased 12-24-1856  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 20 1943 to March 28 1943 that I last saw her alive on March 28 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure acute

8. AGE: Years 86 Months 3 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Chronic asthma

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

Due to \_\_\_\_\_

10. Usual occupation Housewife

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

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

Major findings: Of operations \_\_\_\_\_

12. Name Geo. B. Harlan

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

13. Birthplace \_\_\_\_\_

14. Maiden name Elizabeth Toller

15. Birthplace \_\_\_\_\_

16. (a) Informant G. M. Dickson

(b) Address Ke Salem Mo

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 3-29-1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Keyville cemetery

18. (a) Signature of funeral director J. James

(b) Address Shelville Mo

19. (a) 4-1-43 (b) W. H. Roberts  
(Date received local registrar) (Signature of registrar)

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) \_\_\_\_\_ (Specify means of injury)

23. Signature William H. Key D.D.S. (M.D. or other) \_\_\_\_\_

Address Keelville Mo Date signed 4/1/43

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

2800

RECEIVED

District Health Officer No. 5,

District File Number

543327

Date Filed

5-13-43

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

*embalmed.*

Registered Apprentice No.

*Henry G. Jones*  
*2628*

working under my personal supervision.

Signed

*Henry G. Jones*

Licensed Embalmer No.

*2628*

P. O. Address

*Steele, 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.