4-5-42
4-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18542

MAY 18 1943

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 54

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville (If outside city of town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Nodaway
(c) City or town Maryville (If outside city or town limits, write "RURAL")
(d) Street No. 902 East 2nd (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Anna Belle Dawson
3. (b) If veteran, name war
3. (c) Social Security No. no

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Wm. A. Dawson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 28 1870 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	3	17	hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Jarel Long
13. Birthplace unknown Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jane Mitchell
15. Birthplace unknown Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Virgil Dawson
(b) Address Maryville Missouri
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4-18-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Graham cemetery
18. (a) Signature of funeral director Price Funeral Home
(b) Address Maryville Mo
19. (a) April 16, 1943 (Date received local registrar) (b) Mary Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 15 year 43 hour 12 minute noon M.
21. I hereby certify that I attended the deceased from 2-28-43, 19..., to 4-15, 1943 that I last saw her alive on 4-15, 1943; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Myocarditis
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) Hypertension with fractured nose Severe fall about 2-28-43
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: 0
(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 J. M. Baylor (M. D. or other)
Address Maryville Date signed 4-16-43

(Licensed Embalmer's Statement on Reverse Side)

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

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..... Clem M. Price

Licensed Embalmer No..... 1822

P. O. Address..... Maryville 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.

V. S. No. 2B
DM—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. MC

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 54

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 1 day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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 Belle Dawson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 28 (Day) 18 (Year)
8. AGE: Years 72 Months 3 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Ill (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 — year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death myocarditis	
Due to 180a / 18	
Due to	
Other conditions (Include pregnancy within 3 months of death) Hypertension severe fall with fracture	
Major findings: Of operations Nose abort 2-28-43	
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) Patient fell down over a broom in her home
(b) Date of occurrence about 6 wks before death
(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? The accident was not cause of death
(Specify type of place)
While at work? (e) Means of injury
23. Signature J M Boyles (M. D. or other)
Address Maryville Date signed 1

S-18942