

ED AUG 25 1943

Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 71

## 1. PLACE OF DEATH:

(b) County Clay  
(c) City or town Harlem mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether  
In this community 57 years  
years, months or days)

3. (a) PRINT FULL NAME EARL DAWSON

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color of hair White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Birdie Dawson 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased Jan 11th - 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 7 6 hr. min.

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

10. Usual occupation (Carpenter)

11. Industry or business Business

12. Name Joe Dawson  
13. Birthplace Tilton N.H.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ratie Arfuckle  
15. Birthplace Decatur Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant PAUL - DAWSON

(b) Address R.R. 8 - North K.C. Mo.

17. (a) Burial (b) Date thereof 8-20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation German cemetery

18. (a) Signature of funeral director Morton Funeral Home

(b) Address No. Kan City Mo.

19. (a) Aug 17 - 1943 (b) Butch N. Henry  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay  
(c) City or town Harlem mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. 8 North K.C. Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17th  
year 1943 - hour 7:30 minute AM

21. I hereby certify that I attended the deceased from Aug 17  
1943 to Aug 17 1943  
that I last saw him alive on Aug 17 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis  
Due to 9321  
Due to 9321

Other conditions Arricular Fibrillation  
(Include pregnancy within 3 months of death)  
Passive congestion

Major findings: Passive congestion  
Of operations None

Of autopsy None

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None  
(b) Date of occurrence None  
(c) Where did injury occur? None  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? None (Specify type of place) (Means of injury)

23. Signature Butch N. Henry (M. D. number) None  
Address No. Kan City Mo. Date signed 8-17-43

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-23-43

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.....

working under my personal supervision.

....., Registered Apprentice No.....

Signed

*John L. Manton*

Licensed Embalmer No. 4349-

P. O. Address No. Kan City

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Sept

Registration District No.

72

Primary Registration District No.

5289

Registrar's No.

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Gallatin  
(If outside city or town limits, write "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. (Specify whether years, months or days)

In this community

3. (a) PRINT FULL NAME

Earl Hanson

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex m 5. Color or race w

6. (b) Name of husband or wife

6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or 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. (Date received local registrar)

(b) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1943 Hour 1 Minute 15 M.

21. I hereby certify that I attended the deceased from 19

that I have known him since 19 and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

MOTHER FATHER

27984