No. 2
—5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 27986

ED AUG 25 1943

Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 69

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

**1. PLACE OF DEATH:**

(a) County CLAY

(b) City or town: RR #5 NO-KAN-CITY-MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: RR #5 NORTH-KAN-CITY MO
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 43-YEARS
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County CLAY

(c) City or town RR #5 NO-KAN-CITY MO
(If outside city or town limits, write "RURAL")

(d) Street No. RR #5- NO KAN- CITY MO
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME KETURAH- DIXON

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

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

4. Sex FEMALE

5. Color or race WHT

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

6. (b) Name of husband or wife ROBERT DIXON

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

7. Birth date of deceased JULY (Month) 4th (Day) 1851. (Year)

8. AGE: Years 92 | Months 1 | Days 3 | If less than one day ..... hr. ..... min.

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

10. Usual occupation RETIRED HOUSEWIFE

11. Industry or business NONE

FATHER
12. Name WESLEY WHITE
13. Birthplace SCRANTON (City, town, or county) Pa. (State or foreign country)

MOTHER
14. Maiden name NANCY GEORGE
15. Birthplace ALTON (City, town, or county) ILL (State or foreign country)

16. (a) Informant MRS W-J- COOLEY.

(b) Address RR #5 NO-KAN-C-MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-9-43 (Month) (Day) (Year)

(c) Place: burial or cremation LIBERTY MO

18. (a) Signature of funeral director MORTON FUNERAL HOME

(b) Address NO-KAN CITY MISSOURI

19. (a) Aug 9-43 (Date received local registrar) (b) Ruth N. Henry (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month AUGUST day 7th year 1943 hour 1.30 minute P.M.

21. I hereby certify that I attended the deceased from 7-31, 1943, to 8-7-, 1943; that I last saw her alive on 8-7, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronchial Pneumonia | |
| Due to Fracture Right femur in neck. | |
| 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) Accident

(b) Date of occurrence 7-31-43

(c) Where did injury occur? NO KAN CITY (City or town) Clay (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? no (e) Means of injury Fell

23. Signature Russell G Hodge (M. D. or other)

Address North KC Mo Date signed 8-9-43

(Licensed Embalmer's Statement on Reverse Side)

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 .....

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

working under my personal supervision.

Signed John F. Morton

Licensed Embalmer No. 4349 —

P. O. Address No-KAN-CITY-MO

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
M—5-43
I X36930

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

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 R.R. 5 - No. K.C. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gallatin Twp (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 43 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Clay
(c) City or town 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 Keturah Dixon
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 W
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased July (Month) 4 (Day) 1851 (Year)

8. AGE: Years 92 Months 1 Days ..... Unless than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Pa. (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
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) Aug 27-43 (Date received local registrar) (b) Ruth N. Henry (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug. Day ..... year 1943 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw him alive on ..... 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

279986