

FILED MAR 20 1944  
Registration District No. 333

Primary Registration District No. 3074

State File No. ....

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Sikeston  
(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  
In this community 25 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Scott  
(c) City or town Sikeston  
(If outside city or town limits, write "RURAL")  
(d) Street No. Sunset Addition  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Tom Dixon  
3. (b) If veteran, name war X  
3. (c) Social Security No. X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 31  
year 1944 hour 7 minute 45 a.m.

4. Sex M 5. Color or race C  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Annie B. Dixon  
6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased 3 15 1882  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-21-  
1944 to 1-31-  
1944  
that I last saw him alive on 1-30  
and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months 10 Days 16  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Pneumonia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Unknown Miss.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farm Work

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: ADDITIONAL  
Of operations: SUPPLEMENTARY  
Of autopsy: REQUESTED

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace "  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16: (a) Informant Annie B. Dixon  
(b) Address Sikeston Mo. Gen'l Del box 28  
17. (a) Burial (b) Date thereof 2/1/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sikeston Mo.  
18. (a) Signature of funeral director H.W. Albritton  
(b) Address Sikeston Mo.  
19. (a) 3/5/44 (b) Louis Largent  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other)  
Address [Signature] Date signed 4/5/44

MOTHER FATHER

RECEIVED

District Health Office N

District File Number 344-

Date Filed 3-16-

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.....

Not Embalmed

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

working under my personal supervision.

Signed

*Herbert Albert*

Licensed Embalmer No. 4210

P. O. Address S. keston Mo.

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

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

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

3. (a) PRINT FULL NAME Tom Dixon  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race C 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 Mar. 15 1944  
(Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Miss  
(City, town, or county) (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 \_\_\_\_\_ day \_\_\_\_\_  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Pneumonia Duration \_\_\_\_\_  
Bronchitis

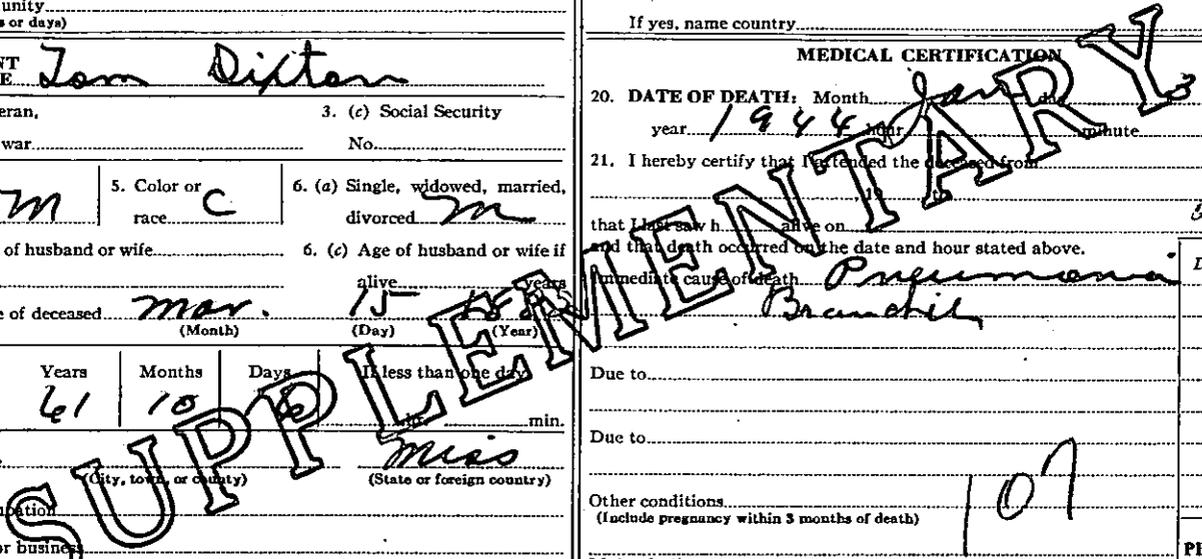
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 107

Major findings:  
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 J. F. Waters (M. D. or other)  
Address Sikeston Mo Date signed \_\_\_\_\_



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