

8. No. 2  
1-5-42  
5-17-39  
PI X32273

State File No. ....

FILED SEP 22 1944

Registration District No. ....

Primary Registration District No. 2000

Registrar's No. 746

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Springfield Baptist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 da.**  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**  
(c) City or town **Rural, Springfield - S. Campbell Twp.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1433 E Olive**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Faye Miller Dickenson**

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

4. Sex **Female** 5. Color or race **wht.** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Merle Franklin Sickenway** 6. (c) Age of husband or wife if alive **29** years  
7. Birth date of deceased **May 16, 1916**  
(Month) (Day) (Year)

8. AGE: Years **28** Months **3** Days **29** If less than one day hr. min.

9. Birthplace **Cross Timbers Mo. U**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Wife**

11. Industry or business

12. Name **Charles Miller**

13. Birthplace **Hickory Co. Mo. U**  
(City, town, or county) (State or foreign country)

14. Maiden name **Cos. A. Harlow**

15. Birthplace **Hickory Co. Mo. U**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Miller**

(b) Address **Spfld, Mo.**

17. (a) **Removal** (b) Date thereof **9-15-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wesley, Mo.**

18. (a) Signature of funeral director **Albert Pathway**

(b) Address **Wheatland, Mo.**

19. (a) **9-16-44** (b) **Dr. W. Handley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **15** year **1944** hour **12** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **8/21**, 1944, to **9/15**, 1944 that I last saw her alive on **9/15** and that death occurred on the date and hour stated above.

Immediate cause of death **Toxemia of pregnancy & Exhaustion** Duration **12nd**  
Due to **Pregnancy & Diabetes Mellitus** **32 wk** **59**

Other conditions (Include pregnancy within 3 months of death) **148 lb**  
Major findings: **Pregnancy 32 wk. Delivery - dead baby 9/15/44**

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) (c) Means of injury.....

23. Signature **Guy D. Callaway** (M. D. or other) **MD**  
Address **Springfield, Mo.** Date signed **9/16/44**

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 *Chas Gilbert Withaway*.....

Licensed Embalmer No. *4267*.....

P. O. Address *Wheatland, MS*.....

**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.**

*X*