

FILED JAN 12 1945

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Lickington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 17th main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community home
years, months or days)

3. (a) PRINT
FULL NAME

BESSIE GRACE DAWSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 2 26 hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name James Dawson
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Simmons
15. Birthplace Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dawson, Neithman
(b) Address Lickington, Mo

17. (a) Buried (b) Date thereof 12-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lickington, Mo

18. (a) Signature of funeral director Forrest F. Jumper
(b) Address Lickington, Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
(c) City or town Lickington
(If outside city or town limits, write "RURAL")
(d) Street No. 17th main
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4
year 1944 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from Nov 28, 44
1944 to Dec 4, 1944
that I last saw him alive on Dec 3rd 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema
resulting from
chronic
Due to Dont know
Duration _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation
Of autopsy yes
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 O. Cope (M. D. or other) _____
Address Lickington Date signed 12/4/44

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

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.

Signed

Licensed Embalmer No.

P. O. Address

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

FILED JAN 13

State File No.

Registration District No. 174

Primary Registration District No. 3026

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Sauvage
(b) City or town Springton
(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 Cessie C. 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

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

7. Birth date of deceased Sept 8 (Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 18 min. If less than one day

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. (a) 12-5-1944 (Date received local registrar) (b) Mrs. Fred Schwaab (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 Dec day 5 year 1944 hour 10 minute 15 M.

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

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

PHYSICIAN

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

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

SUPPLEMENTARY

41436