

No. 2
M-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42043

State File No. _____

FILED DEC 23 1944

Registration District No. _____

Primary Registration District No. 3059

Registrar's No. 232

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
14 Easter St
(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 SHARON RAE TIXON

3. (b) If veteran, name war V

3. (c) Social Security No. V

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased: Aug 1 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

MOTHER FATHER

11. Industry or business _____

12. Name Robert Arthur Dixon

13. Birthplace Bonne Terre Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Wells Boyer

15. Birthplace Wayne Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Addison

(b) Address 14 Easter Bonne Terre Mo

17. (a) Burial (b) Date thereof 11-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerose

18. (a) Signature of funeral director Benjamin H. ...

(b) Address 313 Benton Bonne Terre Mo

19. (a) 11-29-44 (b) James ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

(d) Street No. 14 Easter St
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 25
year 1944 hour 1 minutes 07 A M.

21. I hereby certify that I attended the deceased from Nov 24
1944, to Nov 25 1944
that I last saw her alive on Nov 25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Sabur pneumonia

Due to _____

Due to 108

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 [Signature] (M. D. or other) [Signature]

Address Bonne Terre Date signed 11/29/44

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

REIVED

District Health Officer No. 4
District File Number 1244-4684
Date Filed 12-20-44

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 C. J. Claywell
Licensed Embalmer No. 3706
P. O. Address Same Sec 110

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.