

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 111 N. Denver
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 51 years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 111 N. Denver (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME SARAH M. DECKER

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

4. Sex Fe. / 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widow
6. (b) Name of husband or wife M. L. Dickson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 18, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 16 hr. min.

9. Birthplace Bolton / Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business None

MOTHER FATHER

12. Name ~~Henrietta Wilcox~~ David W. Scott

13. Birthplace Pa. /
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta B. Wilcox

15. Birthplace Hot Springs, / Ark. /
(City, town, or county) (State or foreign country)

16. (a) Informant Lisle Decker

(b) Address 111 N. Denver

17. (a) Burial (b) Date thereof 1/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo

19. (a) 1-6-45 (b) T. E. Brown (U3)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4
year 1945 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from 12/26, 1944, to 1/4, 1945;
that I last saw her alive on 1/4, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic valvular heart disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92

Major findings: Of operations _____

Of autopsy _____

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? _____

23. Signature S. A. Williams (Specify type of place) (Means of injury)
While at work? _____

Address Kansas City, Mo (M. D. or other) Date signed 1/6/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 A. D. Blackman

Licensed Embalmer No. 3639

P. O. Address R. C. Mo

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.