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I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22893

FILED JUL 30 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2957

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: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Weeks (Specify whether years, months or days)
In this community 9 Years

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")
(d) Street No. 14 E. 8th 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elmer Edwin Dickover
3. (b) If veteran, name war No
3. (c) Social Security No. 499-24-0670
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 4
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive)) years
7. Birth date of deceased 1 (Month) 26 (Day) 1868 (Year)
8. AGE: Years 77 Months 5 Days 18 If less than one day hr. min.
9. Birthplace Indiana 1 (City, town, or county) (State or foreign country)
10. Usual occupation Upholsterer
11. Industry or business
FATHER
12. Name Samuel Dickover
13. Birthplace Indiana 1 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Martz
15. Birthplace Indiana 1 (City, town, or county) (State or foreign country)
16. (a) Informant Mr. Howard P. Dickover
(b) Address 5233 Cleveland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn
18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address Kansas City, Mo.
19. (a) 7-16-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1945 hour 3 minute 30 P. M.
21. I hereby certify that I attended the deceased from July 3, 1945 to July 14, 1945 that I last saw him alive on July 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis with cavitation

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy see above

Duration

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 Clark W. Sealy M.D. (M. D. or other)
Address Med. Dir. K.C. General Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....Cortland S. Minor.....

Licensed Embalmer No.....3414.....

P. O. Address.....918 Brooklyn.....

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.