U. S. No. 2
OM—8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25340

FILED AUG 14 1945

Registration District No. 374

Primary Registration District No. 4547

Registrar's No.

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

1. **PLACE OF DEATH:**
(a) County North
(b) City or town Grant City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Life

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Mo. (b) County North 113
(c) City or town Grant City
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Billie Lois Dickerson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F. 1
5. Color or race W.
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 1 (Day) 1938 (Year)

8. AGE: Years 7 | Months 4 | Days 27 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER
12. Name John Dickerson
13. Birthplace Albintale (City, town, or county) Mo. (State or foreign country)
14. Maiden name Vivian Wall
15. Birthplace Grant City (City, town, or county) Mo. (State or foreign country)

16. (a) Informant John Dickerson
(b) Address Grant City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Hazel Grove Cem.

18. (a) Signature of funeral director Geo. C. Dunkle
(b) Address Grant City Mo.

19. (a) July 2 1945 (Date received local registrar) (b) Maysha Rinehart (Registrar's signature)

1385

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 28
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from May 15, 19 45 to June 28, 19 45
that I last saw h. alive on June 28, 19 45
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lymphoblastic Leukemia	3 mo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
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? (Specify type of place)
While at work (e) Means of injury

23. Signature Walter Neal D.O. (M. D. or other)
Address Grant City Date signed 6-29-45

(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 Arch C. Dunbee

Licensed Embalmer No. 3202

P. O. Address Grant City, 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.