

S. No. 2
DOM-5-43
ev. 5-17-39
I X38671

FILED OCT 13 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4109

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: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month & 2 Days
(Specify whether years, months or days)

In this community 20 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 9
(If outside city or town limits, write "RURAL")

(d) Street No. 3200 Norledge 8
(If rural, give location)

(e) Citizen of foreign country? No 0
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JAMES DIXON

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased: August 21st 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>1</u>	<u>13</u>	hr. _____ min.

9. Birthplace: New Haven Connetticut
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: R. R. Maintenance of Way

12. Name: Mark McCann

13. Birthplace: Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name: Ellen Whalen

15. Birthplace: Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant: C. G. Fisher

(b) Address: 920 Columbia National Bank Bldg.

17. (a) Burial (b) Date thereof: 10/ 8/ 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Marys Cemetery

18. (a) Signature of funeral director: Freeman Mortuary & Chapel

(b) Address: 104 West 42nd Street

19. (a) 10-6-45 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4th
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from August 26, 1945, to October 4, 1945
that I last saw him alive on 10-4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Asbestosis, pleurisy, generalized arterio-sclerosis
Due to _____
Duration 5 Wks

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

Major findings: 98:2
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature: J. E. Castle (M. D. _____)

Address: 1002 Argyle Bldg., K.C., Mo. Date signed: 10-5-45

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.....

Elmer C. Wedekin

Licensed Embalmer No. *3495*

P. O. Address *Y. 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.

Dr. Eugene B. ...