

S. No. 2
M-8-43
5-17-39
P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41359

State File No. _____

FILED JAN 5 1946

Registrar's District No. _____

Primary Registration District No. 5-551-3025

Registrar's No. 123

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

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____

(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 George Arthur Dixon

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Sarah C Dixon 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased. 8 (Month) 19 (Day) 1872 (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Dixon

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

14. Maiden name unk

15. Birthplace unk
(City, town, or county) (State or foreign country)

16. (a) Informant Ellis Dixon

(b) Address Correctionville, Ia.

17. (a) _____ (b) Date thereof 11-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Pleasant

18. (a) Signature of funeral director: Robertson

(b) Address West Plains, Mo.

19. (a) 11-21-45 (b) Dudya Harrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) _____

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2
year 1945 hour 3 minute 45 M.

21. I hereby certify that I attended the deceased from June
1945 to Oct 28 1945
that I last saw him alive on Oct-28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Bladder and Prostate Gland
Due to _____

Due to _____

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

Major findings: _____
Of operations 5/15
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)
(b) Means of injury _____

23. Signature W. H. Harrison (Physician)
Address West Plains, Mo

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1019

(Licensed Embalmer's Statement on Reverse Side)

Thornburgh

RECORDED

District Health Officer No. 5,

District File Number 1863

Date Filed 1-2-46

MAY 10 1958

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 *D. A. Robertson*

Licensed Embalmer No. 3435

P. O. Address.....

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.