

No. 8-13
-17-39
X37823

FILED APR 12 1946
Register's District No. **35**

Primary Registration District No. **3011**

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

1. PLACE OF DEATH:
 (a) County **Carroll**
 (b) City or town **Carrollton**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Atwood Hospital.**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days.**
(Specify whether
 In this community **Most of his life. (45yrs)**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Carroll**
 (c) City or town **Carrollton**
(If outside city or town limits, write "RURAL")
 (d) Street No. **117 N. Main Street.**
(If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Henry Edward Dickson.**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **widower**

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

7. Birth date of deceased **June 11 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	8	27	hr. min.

9. Birthplace **Carroll County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer & Grocery Business**

11. Industry or business _____

12. Name **Joe Dickson**

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

14. Maiden name **Elizabeth Cawhorn**

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

16. (a) Informant **Mrs Rose Adams**

(b) Address **117 N. Main St.**

17. (a) **Burial** (b) Date thereof **3-10-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Marshall F. Home.**

(b) Address **Carrollton Mo.**

19. (a) **3/9/46** (b) **Mrs Herbert Calvert**
(Date received local registrar) (Registrar's signature)

MOTHER, FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8th,**
 year **1946** hour **9** minute **50 AM.**

21. I hereby certify that I attended the deceased from **3/5** to **3/8**, 19**46**
 that I last saw him alive on **3/8**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumo-pneumonia
Fracture, neck of femur

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

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? _____

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature **J. H. Platt** (M. D. or other) _____
 Address **Carrollton Mo** Date signed **3/9/46**

CERTIFICATE OF DEATH
 NOT VALID UNLESS
 RETURNED TO REGISTRY

PHYSICIAN

Underline the cause to which death should be charged statistically.

45

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

4-11-76

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 *myself*

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed *P. M. Marshall*

Licensed Embalmer No. *2525*

P. O. Address *Carrollton 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. April
Registrar's No. 76Registration District No. 55Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 days3. (a) PRINT FULL NAME Henry C. Dickson

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

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

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

7. Birth date of deceased June 11 (Month) (Day) (Year)8. AGE: Years 83 Months 8 Days 8 If less than one day _____ hr. _____ min.9. Birthplace MO (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)16. (a) Informant _____
(b) Address _____17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 March
year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____Due to _____
Due to _____Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy Sto 15

22. If death was due to external causes, fill in the following:

(a) Accident, ~~submersion~~ (specify) Fall on bathroom floor(b) Date of occurrence March 5, 1946(c) Where did injury occur? Carrollton Carroll Missouri
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at homeWhile at work? no (Specify type of place) (e) Means of injury fall23. Signature John H. Platz (M. D. no)
Address Carrollton, Missouri Date signed 4/14/46

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

7699

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