

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

34217

FILED OCT 17 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 227

Primary Registration District No. 4339

Registrar's No. 46

1. PLACE OF DEATH:

(a) County. MONROE  
(b) City or town. PARIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: E. MONROE ST.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 65 YRS. (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME HENRY N. DAWSON

3. (b) If veteran. ✓ name war \_\_\_\_\_ 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ALICE DAWSON 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased FEB 10, 1865  
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 28 If less than one day  
hr. min.

9. Birthplace MONROE CO., MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation FIREMAN - STATIONARY BOILER

11. Industry or business

12. Name FRANCES DAWSON

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

14. Maiden name SARAH WILKINSON

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

16. (a) Informant MRS. NINA SCOBEE

(b) Address PARIS, MO.

17. (a) BURIAL (b) Date thereof 9-10-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT GROVE

18. (a) Signature of funeral director Speed & Blakely

(b) Address PARIS, MO.

19. (a) 9-8-46 (b) Elbert Baker, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE  
(c) City or town PARIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. E. MONROE ST.  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 8<sup>TH</sup>  
year 1946 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from SEPT 8  
to SEPT 8 1946  
that I last saw ✓ alive on SEPT 8 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 hr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 8317  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature M. D. Baker (M. D. certifier)

Address PARIS, MO. Date signed 9-8-46

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

RECEIVED  
District Health Officer No. 10  
Division for Health  
OCT 14 1945  
10:46 AM '45

### 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..... *E. H. Agnew* .....

Licensed Embalmer No. 4000

P. O. Address..... Paris, Missouri .....

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.