

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

36933

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4683**

Registration District No. 149 Primary Registration District No. 1002

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

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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 DAYS
(Specify whether years, months or days)

In this community 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 2300 TROOST
(If rural, give location)

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

3. (a) PRINT FULL NAME COTHION DICKERSON

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex MALE 5. Color or race NEGRO

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

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

7. Birth date of deceased APRIL 18, 1916
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>6</u>	<u>6</u>	hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 18, year 1946 hour 9: minute 40 P. M.

21. I hereby certify that I attended the deceased from OCTOBER 7, 19 46 to OCTOBER 18, 19 46 that I last saw him alive on OCTOBER 18, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death TOXEMIA OF JAUNDICE Duration _____

Due to POSSIBLE CHOLELITHIASIS

Due to _____

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

Major findings: _____
Of operations: _____

Of autopsy: _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace LITTLE ROCK ARKANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name HARDIS DICKERSON

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

14. Maiden name DONZELLA ELDON

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

16. (a) Informant HOWARD DICKERSON (BROTHER)
(b) Address 2300 TROOST

17. (a) burial (b) Date thereof 11-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of funeral director Wm. A. Johnson
(b) Address 2300 Troost

19. (a) 11-8-46 (b) Thereldine Holmes
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature [Signature] (M. D. or other M. D.)
Address GENERAL HOSPITAL NO. 2 Date signed 10/19/46

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 *N. M. A. Schuyler*.....

Licensed Embalmer No. *3089*.....

P. O. Address *17 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.