

FILED JAN 27 1947

Registration District No. **374**

Primary Registration District No. **4549**

Registrar's No. **2**

1. PLACE OF DEATH

(a) County **Monroe**  
(b) City or town **Attendale**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 mo. 9 da** (Specify whether years, months or days)  
In this community

3. (a) PRINT FULL NAME **George W. Dickerson**

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 **Martha** 6. (c) Age of husband or wife if alive years **13** 1859 (Month) (Day) (Year)  
7. Birth date of deceased **May 13 1859**

8. AGE: Years **87** Months **7** Days **26** If less than one day hr. min.

9. Birthplace **Indianapolis Ind.** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **S. B. Dickerson**

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

14. Maiden name **Charinda Sturgen**

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

16. (a) Informant **Mrs. Gora Hammer**

(b) Address **Attendale Mo**

17. (a) **BURIAL** (b) Date thereof **Jan-12-1947** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial **Kellerton Iowa**

18. (a) Signature of funeral director **C. O. Rhoades**

(b) Address **7222 Mt. Airy Iowa**

19. (a) **JAN. 12 47** (b) **L. E. Duvall** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **Ringgold**  
(c) City or town **Mount Airy Iowa** (If outside city or town limits, write "RURAL")  
(d) Street No. **0** (If rural, give location)  
(e) Citizen of foreign country? **—** (Yes or No)  
If yes, name country **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **9** year **1947** hour minute M.

21. I hereby certify that I attended the deceased from **Dec 1** 1946 to **Jan 9** 1947 that I last saw him alive on **Jan 7** 1947 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial degeneration** **5 yrs**  
**HT. Robert**

Due to **—**

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.

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

(a) Accident, suicide, or homicide (specify) **—**

(b) Date of occurrence **—**

Where did injury occur? **—** (City or town) (County) (State)

(d) Did injury occur on or about home, on farm, in industrial place, in public place? **—**

While at work? **—** (Specify type of place) (e) Means of injury **—**

23. Signature **—** (Dr. or other)

Address **—** Date signed **—**

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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

*C. D. Rhoads*

Licensed Embalmer No. *2479*

P. O. Address

*Mount Airy, Ia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with  
the constitutes grounds for revocation of license.)

not embalmed, fact should be so stated above.