

No. 2
-12-45
5-17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9016
Registrar's No. 1053

FILED MAR 21 1947

Registration District No. 1002 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

(c) Name of hospital or institution: General Hospital #1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 1 week (Specify whether years, months or days)

In this community 80 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM DICKERSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife May Holcomb

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Dec. 28 1856
(Month) (Day) (Year)

8. AGE: Years 91 Months 2 Days 10 If less than one day hr. min.

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

10. Usual occupation Retail farmer

11. Industry or business

12. Name Absolom Dickerson

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

14. Maiden name Alma Thompson
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. May Dickerson

(b) Address Harrison, Mo.

17. (a) Removal (b) Date thereof 3/8/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond, Mo.

18. (a) Signature of funeral director Wm. W. Hart

(b) Address Richmond, Mo.

19. (a) 3-8-47 Wm. W. Hart
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89

(c) City or town Harrison 0
(If outside city or town limits, write "RURAL")

(d) Street No. W. St. W. Harrison 0
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th
year 1947 hour 7 minute 48 P.M.

21. I hereby certify that I attended the deceased from 3-1-47 to 3-8-47
1 1947 to 3-8 1947

that I last saw him alive on 3-8-47
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease Duration

Cardiac failure

Pneumonia Broncho

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93

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 Wm. W. Hart (M. D. or other) MD

Address Hon. Hoop #1 Date signed

Stenberg
Sapp

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 George H. Hile
Licensed Embalmer No. 4066
P. O. Address. Richmond, Va.

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.