

Registration District No. 374

Primary Registration District No. 6276

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural Union township
(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 3 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME SAMUEL ORREN DAWSON

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 divorced
6. (b) Name of husband or wife Elizabeth Dawson 6. (c) Age of husband or wife if alive death years
7. Birth date of deceased March 4 1878 (Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 21 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Samuel Thomas Dawson
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Dawson
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant John C. Dunfee
(b) Address Franklin, Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof 2-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director John C. Dunfee
(b) Address Franklin, Mo.
19. (a) March 7-47 (b) John E. Dawson (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Worth
(c) City or town Rural (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 2 day 25 year 1947 hour 11 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb 20, 1947, to Feb 21, 1947, that I last saw him alive on Feb 21, 1947, and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia

Due to
Due to
Other conditions Heart Trouble
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
ADDITIO SUPPLE INFOR REQUESTED

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 Egbert Croson (M. D. or other)
Address Paris, Mo. Date signed Feb 28

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.....

John C. Dingle

Licensed Embalmer No.

3252

P. O. Address.....

Grant City 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.