

FILED MAY 8 1947

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

Registration District No. 219

Primary Registration District No. 5786

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Mississippi  
 (b) City or town Charleston, Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
10 mi. NE of Charleston  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
All of Life (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Wilma Lorene Dixon

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: March 28, 1947  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	20	hr. _____ min. _____

9. Birthplace: R#2, Charleston, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: Infant

11. Industry or business: None

MOTHER FATHER

12. Name: Olie Dixon

13. Birthplace: Mississippi Co., Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name: Etha Scott

15. Birthplace: Mississippi Co., Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant: Olie Dixon

(b) Address: R#2, Charleston, Missouri

17. (a) Burial (b) Date thereof: 4-17-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove Cemetery, Charleston, Missouri

18. (a) Signature of funeral director: Private

(b) Address: \_\_\_\_\_

19. (a) 4-23-47 (b) Mrs. John Bondurant  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
 (c) City or town Charleston, Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 10 mi. NE of Charleston  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th  
 year 1947 hour 4:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4-16-1947 to 4-16-1947  
 that I last saw her alive on 4-16-1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death: anoxia atelectasis  
 Due to \_\_\_\_\_

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

Other conditions: \_\_\_\_\_  
(include pregnancy within 3 months of death)

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

Of autopsy: \_\_\_\_\_

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature: W. J. Lugal (M.D. or other) \_\_\_\_\_

Address: 204 S. Locust St. Charleston, Mo. 4-17-47

Duration

1 day.

Who

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2,

District File Number 547-657

Date Filed 5-5-47

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.

*Not Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.