

FILED JUN 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19024

State File No.

Registration District No. 23Primary Registration District No. 5345Registrar's No. 48

1. PLACE OF DEATH:

Dade
(a) County
(b) City or town Greenfield, Mo. Rural
(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.....
In this community..... Life Long
years, months or days

3. (a) PRINT FULL NAME Malinda E. Dicus3. (b) If veteran, name war..... /
3. (c) Social Security No. /4. Sex F 3 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Mark A. Dicus Deceased 6. (c) Age of husband or wife if alive..... years7. Birth date of deceased Nov. 4 1855
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
92 7 2 hr. min.9. Birthplace Dade C.o.
(City, town, or county) (State or foreign country)10. Usual occupation House Wife

11. Industry or business

12. Name Maniel E. Dicus13. Birthplace Tenn.
(City, town, or county) (State or foreign country)14. Maiden name Maniel Dicus
Tenn.15. Birthplace
(City, town, or county) (State or foreign country)16. (a) Informant Homer Tripplett
(b) Address Greenfield, Mo.17. (a) Burial (b) Date thereof June 9, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenfield Mo.18. (a) Signature of funeral director W. R. Allison(b) Address Greenfield, Mo.19. (a) 6-9-48 (b) Geo. P. West
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dade
(c) City or town Greenfield Mo. Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1948 hour 3:00 minute P.M.21. I hereby certify that I attended the deceased from 5/24/48, 19... to 6/6/48, 19...
that I last saw her alive on 5/24/48, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death

Fractured Lt. Hip Duration 2 wks.

Due to.....

Due to.....

Other conditions Malnutrition
(Include pregnancy within 5 months of death)

Major findings:

Of operations..... 14 to 16Of autopsy..... 10 14

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

(a) Accident, suicide, or homicide (specify) Accident(b) Date of occurrence 5/24/48(c) Where did injury occur? (Home) Dade Co. Mo.
(City or town) (County) (State)(d) Did injury occur near about home, on farm, in industrial place, in public place?
In own home;

While at work? (Specify type of place)

(e) Means of injury Fell23. Signature Alvin R. Cairns (M.D. or Other)Address Greenfield, Mo. Date signed 6/9/48

RECEIVED

District Health Officer No. 6;

District File Number 648-698

Date Filed JUN 15 1958

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.....

George W. Newcomb, Registered Apprentice No. 30
working under my personal supervision.

Signed W. R. Allison
Licensed Embalmer No. 4404
P. O. Address Greenfield, N.H.

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

If this body is not embalmed, fact should be so stated above.