

FILED AUG 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26668

BIRTH NO. _____		REG. DIST. NO. <u>125</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>736</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Alabama</u> b. COUNTY <u>Jefferson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Birmingham</u>		<u>777</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1016 West 59th, Fair View Sta. 2</u>				
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Maybie</u>		b. (Middle) <u>Dickinson</u>		c. (Last) <u>Stanley</u>	
4. DATE OF DEATH		(Month) <u>August</u>		(Day) <u>17</u>		(Year) <u>1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov 30, 1895</u>		
9. AGE (In years last birthday) <u>53</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 100 HRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>			11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>Walter L Dickinson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Greene</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lynwood C. Dickinson, Springfield, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>						
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Ca of Bladder + urea</u>				<u>20 yrs</u>		
		DUE TO (c) _____						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Hypertension</u>				<u>10/98</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>No surgery</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>8-10, 1949</u> , to <u>8-17, 1949</u> , that I last saw the deceased alive on <u>8-17, 1949</u> , and that death occurred at <u>1:15 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Type or Print) <u>M. G. Handley M.D.</u>				23b. ADDRESS <u>Med. Bldg. Supt. Bldg.</u>		23c. DATE SIGNED <u>8-18-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>August 18, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Amory Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Amory, Mississippi</u>		
DATE REC'D BY LOCAL OFF. <u>8-18-49</u>		REGISTRAR'S SIGNATURE <u>M. G. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer</u>		ADDRESS <u>F.H. Springfield, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 13 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed

*Jewell E. Kindt*  
Licensed Embalmer No. 2831  
P.O. Address Springfield

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.