

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 4353 State File No. 27489

FILED SEP 9 1949

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BIRTH NO. REG. DIST. NO. 237 PRIMARY REG. DIST. NO. 5840 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>FEMISCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Peach Orchard.</u> 78	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hopkins Clinic</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mabel</u>	b. (Middle) <u>Moline</u>	c. (Last) <u>Dickens</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 5, 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-23-1920</u>	9. AGE (In years last birthday) <u>28</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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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	11. BIRTHPLACE (State or foreign country) <u>Stoddard County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Odie H. Crane</u>	13b. MOTHER'S MAIDEN NAME <u>Beulah Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Laman Dickens</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Laman Dickens</u>	ADDRESS <u>Peach Orchard, Mo.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Valvular Heart Disease</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4214</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 2-27, 1946, to 3/5, 1949, that I last saw the deceased alive on 3/5, 1949, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title)	23b. ADDRESS <u>Gideon, Mo.</u>	23c. DATE SIGNED <u>8/27/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/7/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Stanfield</u>	24d. LOCATION (City, town, or county) (State) <u>near Charleston, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-31-49</u>	REGISTRAR'S SIGNATURE <u>Mr. Byron Sharp</u>	215	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>[Address]</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 6 1949
District Health Office No. 2
District File Number 949-885
Date Filed _____

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.

Student
Student Embalmer

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.