

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26483

State File No. _____

FILED AUG 27 1951

BIRTH NO. Aug 13-51 REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Dade</u> <u>0290</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lockwood</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Everton</u> <u>0290</u>	
c. LENGTH OF STAY (this place) <u>72 Days</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lockwood Memorial Hospital</u>			

3. NAME OF DECEASED (First) <u>CHARLES</u> (Middle) <u>ALBERT</u> (Last) <u>DICKINSON</u>			4. DATE OF DEATH (Month) <u>8</u> (Day) <u>8</u> (Year) <u>51</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 10, 1872</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>IND. I</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>ALBERT DICKINSON</u>		13b. MOTHER'S MAIDEN NAME <u>HATTIE HUYCK</u>		14. NAME OF HUSBAND OR WIFE <u>ORA ANN DICKINSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ORA ANN DICKINSON EVERTON 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		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>331X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 June 5th, 1951, to 8-8, 1951, that I last saw the deceased alive on 8-8, 1951, and that death occurred at 10:20 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Max Heilbrunn</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Lockwood, Mo</u>		23c. DATE SIGNED <u>8-8-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-10-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeler Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Dade Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8-13-51</u>	REGISTRAR'S SIGNATURE <u>Geo L. Weir</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BRIM FUNERAL SERVICE Ash Grove Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED AUG 21 1951
Dist. File 854-1522
Date Filed 8-22-51

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED AUG 21 1951
Dist. File _____
Date Filed _____

AUG 31 1951

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 Monroe D. Notley

Licensed Embalmer No. 4005

P. O. Address Box Grove 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.