

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30090**

FILED OCT 4 1951

BIRTH NO. _____ REG. DIST. NO. **138** PRIMARY REG. DIST. NO. **5521** Registrar's No. **19**

430

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

1. PLACE OF DEATH a. COUNTY Hickory		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Hickory	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermitage		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermitage	
c. LENGTH OF STAY (in this place) 23 years		d. STREET ADDRESS (If rural, give location) East part of town	
d. FULL NAME OF HOSPITAL OR INSTITUTION East part of town			

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Alvin c. (Last) Dickenson			4. DATE OF DEATH (Month) (Day) (Year) Sept 24-1951		
5. SEX MALE		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH MAR 21-1878		9. AGE (In years last birthday) 73		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Stock Farmer		11. BIRTHPLACE (State or foreign country) Fristoe, Mo	

13a. FATHER'S NAME Fountain Dickenson		13b. MOTHER'S MAIDEN NAME Anabelle Doake		14. NAME OF HUSBAND OR WIFE Grace Dickenson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Grace Dickenson-Hermitage Mo	

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) Larynx left leg ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4501		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)		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 **Sept 1, 1951**, to **Sept 24, 1951**, that I last saw the deceased alive on **Sept 20, 1951**, and that death occurred at **1:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE G. G. Dubois (Degree or title) MD		23b. ADDRESS Bolivar Mo		23c. DATE SIGNED 9-28-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Sept 26-1951		24c. NAME OF CEMETERY OR CREMATORY Cross Timbers Cemetery	
				24d. LOCATION (City, town, or county) (State) Cross Timbers Mo	

DATE REC'D BY LOCAL REG. Sept 29, 1951		REGISTRAR'S SIGNATURE HLS		25. FUNERAL DIRECTOR'S SIGNATURE Goldie Holley ADDRESS Bolivar Mo	
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RECEIVED 10-3-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 10-3-51

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

Chas Gilbert R. Howard

Licensed Embalmer No. 4267

P. O. Address *2 Heathland, Md*

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.