

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13308

0495

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar No. 163

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived, or institution, residence before admission). a. STATE Missouri b. COUNTY McDonald	
b. CITY OR TOWN Joplin		c. CITY OR TOWN Anderson 0600	
d. FULL NAME OF HOSPITAL OR INSTITUTION Joplin General		d. STREET ADDRESS (If rural, give location) Route 2 1	
3. NAME OF DECEASED (Type or Print) a. (First) Carlyn b. (Middle) Sue c. (Last) Dickson		4. DATE OF DEATH (Month) (Day) (Year) April 7, 1952	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Sept. 1, 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 3
11. BIRTHPLACE (State or foreign country) Southwest City, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James T. Dickson		13b. MOTHER'S MAIDEN NAME Viola Scantlin	
14. NAME OF HUSBAND OR WIFE --		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James T. Dickson, Anderson, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>			
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH a. Acute medullary & circulatory failure ANTECEDENT CAUSES DUE TO (b) Overwhelming toxidrome DUE TO (c) Necrotic gangrenous appendicitis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Mandibular, maxillary parodontitis			INTERVAL BETWEEN ONSET AND DEATH 6 hrs 7 days 5 days
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION appendicitis, parodontitis, necrotic gangrenous	
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) 5501	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS 521 W 4th Joplin Mo	
23c. DATE SIGNED 4/8/52		24a. BUPIAL CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 4-7-52		24c. NAME OF CEMETERY OR CREMATORY Anderson, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. F. Burns Funeral Home, Bentonville, Ark.	
DATE REC'D BY LOCAL REG. 4-10-52		REGISTRAR'S SIGNATURE Ed S. James 138	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 4-14-52
Jasper. County Health Office

County File Number 52/4/293

Date Filed 4-14-52

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 _____

working under my personal supervision.

Student Embalmer No.

Signed F. M. Jones

Signed.....
Student Embalmer

Licensed Embalmer No. 2319

P. O. Address Jasper, 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.