

AUG 6 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25076**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **229**

1. PLACE OF DEATH a. COUNTY Missouri Marion 0644		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion 0644	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering		d. STREET ADDRESS (If rural, give location) 213 North Seventh	

3. NAME OF DECEASED (Type or Print) Katheryn Dickason			4. DATE OF DEATH (Month) (Day) (Year) July 19, 1952		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH October 28, 1864	9. AGE (In years last birthday) 87	10. MONTH 8 DAY 21 HOUR MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX		10b. KIND OF BUSINESS OR INDUSTRY XX		11. BIRTHPLACE (City and State or Foreign Country) Iowa /	

13a. FATHER'S NAME Thomas Lippincott	13b. MOTHER'S MAIDEN NAME Elizabeth Bennum	14. NAME OF HUSBAND OR WIFE W.A. Dickason (deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ray Roland ADDRESS 213 North Seventh Hannibal
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage -		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	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 **July 5, 1952**, to **July 19, 1952**, that I last saw the deceased alive on **July 19, 1952**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) Doctor M.D.	23b. ADDRESS Hannibal Mo.	23c. DATE SIGNED July 23/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/21/1952	24c. NAME OF CEMETERY OR CREMATORY Mount Olivet	24d. LOCATION (City, town, or county) (State) Hannibal Missouri
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DATE REC'D BY LOCAL REG. 7-23-52	REGISTRAR'S SIGNATURE [Signature]	25. GENERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Hannibal Missouri
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 4 1952
MARION CO. HEALTH DEPT.
DATE FILED AUG 4 1952

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

John S Ward

Licensed Embalmer No. 4540

P. O. Address Hannibal Missouri

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.