

FILED JAN 15 1957

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3403**

No. 300  
10-48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **340** PRIMARY REG. DIST. NO. **L152** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY OR TOWN <b>Dexter, Liberty Twp.</b>	c. LENGTH OF STAY (in this place) <b>Few days</b>	c. CITY OR TOWN <b>Bernie</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Davis Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>St. 1</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Frank</b>	b. (Middle)	c. (Last) <b>Dixson</b>	4. DATE OF DEATH (Month) (Day) (Year)	<b>Jan. 9, 1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>May 13, 1909</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Elsel Dixson</b>	13b. MOTHER'S MAIDEN NAME <b>Janie Rice</b>	14. NAME OF HUSBAND OR WIFE <b>Alvora Dixson</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Alvora Dixson</b>	ADDRESS <b>Rt. 1 Bernie</b>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Abscess Brain &amp; Ears</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>meningitis</b> DUE TO (c) <b>Abscess Ear</b>		
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	<b>3912</b>	20. AUTOPSY? <b>2</b> 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)
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?

22. I hereby certify that I attended the deceased from **Jan. 4<sup>th</sup>**, 1957, to **Jan. 9**, 1957, that I last saw the deceased alive on **Jan. 7**, 1957, and that death occurred at **4:30** m., from the causes and on the date stated above.

23a. SIGNATURE <b>S. L. H. [Signature]</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Dexter, Mo.</b>	23c. DATE SIGNED <b>1-12-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-13-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Burke Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Blythville, Ark.</b>
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DATE REC'D BY LOCAL REG. <b>1-12-57</b>	REGISTRAR'S SIGNATURE <b>Valma D. Jenkins</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Duffie</b>	ADDRESS <b>Bernie, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

409-0

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 47

P. O. Address, Bernie, .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.