

FILED JUL 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

501257 027378

Registration District No. 42-2 Primary Registration District No. 5I33 Registrar's No. 762

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cosby Marion - Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cosby R#1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cosby R#1.</u>		Length of stay in lb <u>53 years.</u>	d. STREET ADDRESS (If outside, give location) <u>R#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Mae</u> Last <u>Dixon</u>			4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1957.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 29, 1881</u>	9. AGE (In years last birthday) <u>75</u>	F UNDER 1 YEAR Months <u>12</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and state or country) <u>DeKalb County, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Jesse Van Cleave</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Archdekin</u>		14. NAME OF HUSBAND OR WIFE <u>Clarence C. Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Clarence C. Dixon Cosby, Mo. R#1.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>8 months</u> <u>or ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u>1:15 PM</u> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>November</u> to <u>48</u> and last saw her alive on <u>July 9 - 1957</u> Death occurred at <u>1:15 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Neva M. Steidley DO</u> (Degree or title)			22b. ADDRESS <u>801 - 2 Francis St Joseph, Mo</u>		22c. DATE SIGNED <u>July 15 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 15, 1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>July 17, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Albert E. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. ... Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.