

Health, & Welfare
Public Health Service

5. 300

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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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38825

FILED NOV 12 1957

STATE FILE NUMBER

Registration District No. 323 Primary Registration District No. 6091 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Saline</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>Rural - Saltpond</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Centralia Mo</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>3 1/2 miles West of Sweet Springs Mo</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>9 1/2 miles N.E. of Centralia Mo</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Helen</u> Last <u>Dickerson</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</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>Jan 20, 1917</u>	9. AGE (In years last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u>4</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Prosperity, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Claude Strickland</u>		13b. MOTHER'S MAIDEN NAME <u>Carra Moore</u>	14. NAME OF HUSBAND OR WIFE <u>John F. Dickerson</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.	17. INFORMANT Address <u>John F. Dickerson, Centralia Mo</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>Broken neck & crushed skull</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Automobil Collision Accident.</u>			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Automobil Collision</u>		
20c. TIME OF BURIAL Hour <u>3:00</u> a.m. Month, Day, Year <u>11-3-57</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, field, etc.) <u>On 40. 3 1/2 miles N.E. of Sweet Springs Salt Pond</u>		20f. CITY, TOWN, OR LOCATION <u>Saline Mo.</u>	
21. I attended the deceased from Death occurred at <u>3:30 P.M.</u>		to _____ and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. L. Lawless M.D. Coroner Saline Co.</u>		(Degree or title) <u>3</u>		22b. ADDRESS <u>Marshall Mo.</u>	
22c. DATE SIGNED <u>11-3-57</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 6, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City of Centralia Cemetery</u>	
				23d. LOCATION (City, town, or county) (State) <u>Centralia, Missouri</u>	
24. FUNERAL DIRECTOR <u>Edgar J. Mosley</u>		ADDRESS <u>Sweet Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 3, 1957</u>	
				26. REGISTRAR'S SIGNATURE <u>Mary Mosley</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

NOV 14 1957

MAR 19 1959

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 *Edgar L Mosely*

Licensed Embalmer No. *4711*

P. O. Address *Sweet Springs, 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.