

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41056

STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 131

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Brookfield</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>Dr. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>558 2nd St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edith</u> Last <u>Tucker</u>			4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>57</u>		
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5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1875</u>	9. AGE (In years last birthday) <u>82</u>	F UNDER 1 YEAR Months _____ Days _____	I F UNDER 24 HRS. Hours _____ Min. _____
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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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>0</u>
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13a. FATHER'S NAME <u>Nelson H. Dickinson</u>	13b. MOTHER'S MAIDEN NAME <u>Jeanne Bullock</u>	14. NAME OF HUSBAND OR WIFE _____
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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) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. W. A. Southerland</u> Address <u>Brookfield</u>
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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>myocarditis acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	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 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.) _____
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 _____
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21. I attended the deceased from <u>Nov - 1</u> to <u>Nov - 8</u> and last saw ^{her} _{him} alive on <u>Nov - 7th</u> . Death occurred at <u>7:45A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>H. H. Patten</u> (Degree or title) <u>PO</u>	22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>11-9-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-10-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knifong</u>	23d. LOCATION (City, town, or county) (State) <u>Browning Mo.</u>
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24. FUNERAL DIRECTOR <u>Wade Funeral Home</u> ADDRESS <u>Browning, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-13-1957</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Dep.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

300

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 *Gerald J. Wade*

Licensed Embalmer No. *4172*
P. O. Address *.....*

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.