

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032297

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4671

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 93 days		c. CITY OR TOWN Smithton		Inside Limits Yes ☐ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA. Hospital		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) Rural Route # 1		Reside on Farm Yes ☐ No ☐	
3. NAME OF DECEASED (Type or print) First Charles Middle Maywood Last Dickinson				4. DATE OF DEATH Month September Day 26 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐		8. DATE OF BIRTH 2-14-1887	
9. AGE (last birthday) 72		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nightwatchman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Mayberry, Nebraska		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Edwin Charles Dickinson		13b. MOTHER'S MAIDEN NAME Rose Anna Blazier		14. NAME OF HUSBAND OR WIFE Eva V. Dickinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 7-8-18 to 1-25-19		16. SOCIAL SECURITY NO. 492-14-5458		17. INFORMANT Address Official Records, VA Hospital, K. C. Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary congestion and edema DUE TO (b) generalized peritonitis DUE TO (c) mesenteric thrombosis, post operative status PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐		20a. ACCIDENT SUICIDE HOMICIDE ☐ ☐ ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Sedalia, Mo.		COUNTY STATE	
21. I attended the deceased from 6-25-59 to 9-26-59 Death occurred at 4:30A. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) J. A. Turner M.D.				22b. ADDRESS VA. Hospital, Kansas City, Mo.		22c. DATE SIGNED 9-26-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9-26-59		23c. NAME OF CEMETERY OR CREMATORY Smithton Cemetery		23d. LOCATION (City, town, or county) (State) Sedalia, Mo.	
24. FUNERAL DIRECTOR D. W. Newcomer's Sons		ADDRESS 1331 Brush Creek		25. DATE RECD. BY LOCAL REG. 9-26-59		26. REGISTRAR'S SIGNATURE Elva Marshall	

VS NOV 3 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.