

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014352

FILED VS MAY 16 1960 43

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 261

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <i>Butler County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Wayne</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Caplar Bluff</i>		Length of stay in 1b <i>8 mo.</i>	c. CITY OR TOWN <i>Mc Lee</i>
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Doctors Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Route 1,</i>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>IRA</i> Middle <i>GENE</i> Last <i>DICKINSON</i>			4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1960</i>			
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2-18-1936</i>	9. AGE (last birthday) <i>24</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>11</i>	IF UNDER 24 HR Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>International Shoe Co.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Factory - Shoe</i>	11. BIRTHPLACE (City and state or country) <i>Mc Lee, Missouri</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Leslie Benjamin Dickinson</i>	13b. MOTHER'S MAIDEN NAME <i>Alma Van Matre</i>	14. NAME OF HUSBAND OR WIFE <i>Mc Lee, Mo.</i>
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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 <i>Yes 11-24-1954 to 8-22-1958</i>	16. SOCIAL SECURITY NO. <i>490-44-9961</i>	17. INFORMANT <i>Alma Van Matre Dickinson</i>	Address <i>Mc Lee, Mo.</i>
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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) <i>Contusion of Brain</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>
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) <i>Multiple fractures, Traumatic pneumothorax</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.) <i>Acute accident near road, mo.</i>
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20c. TIME OF INJURY Hour <i>5:00</i> p.m. Month, Day, Year <i>April 28, 1960</i>

20d. INJURY OCCURRED WHILE AT WORK <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 <i>Arab, Mo.</i>	COUNTY	STATE
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21. I attended the deceased from <i>4-28-60</i> to <i>4-29-60</i> and last saw her/him alive on <i>4-29-60</i> Death occurred at <i>3:30</i> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Ernest T. Hansborough MD</i>	22b. ADDRESS <i>Caplar Bluff, Mo</i>	22c. DATE SIGNED <i>4-28-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-29-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bush Creek</i>	23d. LOCATION (City, town, or county) (State) <i>Arab, Mo.</i>
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24. FUNERAL DIRECTOR <i>W. H. Meyers, Arkansas, Mo.</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>5/3/60</i>	26. REGISTRAR'S SIGNATURE <i>R. H. Huetter</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W. H. Morgan
Licensed Embalmer No. 464

P. O. Address Advance

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.