

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-042378

VS DEC 14 1960

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 582

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Independence</i>	Length of stay in 1b <i>36 yrs</i>	c. CITY OR TOWN <i>Independence</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Indep. Sanitarium</i>		d. STREET ADDRESS (If outside, give location) <i>1517 So. Pleasant</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Claborn</i> Middle <i>J.</i> Last <i>Dixon</i>			4. DATE OF DEATH Month <i>Dec</i> Day <i>6</i> Year <i>1960</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-1886</i>	9. AGE (last birthday) <i>76</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (City and state or country) <i>Berrydale, Fla.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Samuel Dixon</i>		13b. MOTHER'S MAIDEN NAME <i>Clara Bracken</i>		14. NAME OF HUSBAND OR WIFE <i>Callie Dixon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>499-07-4082</i>	17. INFORMANT Address <i>Callie Dixon 1517 S. Pleasant</i>		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>Bronchial Asthma + Emphysema</i> <i>Residuals of Cerebral Vascular Accident with left hemiparesis</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Prostatic hypertrophy with obstruction</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 Month, Day, Year a.m. p.m.	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 COUNTY STATE

21. I attended the deceased from *5-16-55* to *12-6-60* and last saw him alive on *12-5-60*
 Death occurred at *2:27 a.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Berneth A. Mangels, M.D.</i>		22b. ADDRESS <i>Independence, Mo</i>		22c. DATE SIGNED <i>12-7-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-8-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mound Grove Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Independence, Mo</i>		
24. FUNERAL DIRECTOR <i>Roland R. Speake</i>		ADDRESS <i>Indep. Mo</i>	25. DATE RECD. BY LOCAL REG. <i>12-8-60</i>	26. REGISTRAR'S SIGNATURE <i>James K. [Signature]</i>	

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indip. 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.