

FILED JUN 29 1948
Registration District No. **1948**

Primary Registration District No. **3023**

1. PLACE OF DEATH:
(a) County **Henry**
(b) City or town **Clinton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
217 W. Benton (Albany)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 yr.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Henry**
(c) City or town **Clinton**
(If outside city or town limits, write "RURAL")
(d) Street No. **217 W. Benton**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Albert W. Hixson**
(b) If veteran, _____
3. (c) Social Security No. **493-12-7520**
name war _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **6** day **24**
year **1948** hour **1** minute **30 A.M.**

4. Sex **ml** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Dec. 10 1914**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5/18** 19**44**, to **6-24** 19**48**
that I last saw him alive on **6/23** 19**48**
and that death occurred on the date and hour stated above.
Duration _____

8. AGE: Years **33** Months **6** Days **14**
If less than one day _____ hr. _____ min.

Immediate cause of death **Syphilis of the antihel nervous system 6 yrs.**
Due to _____
Due to _____

9. Birthplace: **Linn Co. Kansas**
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **Doctor**

11. Industry or business **Railroad**

Major findings: _____
Of operations: _____
Of autopsy: _____

12. Name **Joseph F. Hixson**

13. Birthplace **Platteau Mo. (?)**
(City, town, or county) (State or foreign country)

14. Maiden name **Ma. M. Keckler**

15. Birthplace **St. Joseph Mo. (?)**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. J. Hixson**

(b) Address **Clinton Mo.**

17. (a) **Burial** (b) Date thereof **6-26-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Englewood Cem.**

18. (a) Signature of funeral director **Paul W. Hixson**

(b) Address **Clinton Mo.**

19. (a) **6-25-48** (b) **R. R. Remmey**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury **2**

23. Signature **R. J. Powell** (M.D. or other) **190**
Address **Clinton Mo.** Date signed **6/24/48**

MOTHER FATHER

WHILE FILING - USING UNFADING BLACK INK - MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 7
District File Number 5-48-685
Date Filed 6-28-48

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 _____

W. R. Beal's Jr.

Registered Apprentice No. *517*

working under my personal supervision.

Signed _____

[Signature]

Licensed Embalmer No. *4516*

P. O. Address *Clinton, Md.*

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 this body is not embalmed, fact should be so stated above.