

FILED **CERTIFICATE OF DEATH**
Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 577

DO NOT WRITE ON THIS STUB

VS 300
Rev. 11/72

7b-c. 1320

7d. 95001

8. 29

14a. 29

14b. 187

14c-d. 13201

14a. 035

23. 1003546

26a. 2

18-U. 4409

18-S-1.

18-S-2.

20a-f.

20g-St.

20g-Co.

20g-Cy.

Type or print in PERMANENT BLACK INK. See handbook for instructions.

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

PARENTS

CAUSE

CERTIFIER

BURIAL

DECEASED—NAME FIRST MIDDLE LAST 1. Katherine Belle Dixon			SEX 2. Female	DATE OF DEATH (MONTH, DAY, YEAR) 3. December 9-1974
RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY) 4. White	AGE—LAST BIRTHDAY (YEARS) MOS. DAYS 5a. 85	UNDER 1 YEAR 5b.	UNDER 3 DAY 5c.	DATE OF BIRTH (MONTH, DAY, YEAR) 6. SEPTEMBER-6-1889
CITY, TOWN, OR LOCATION OF DEATH 7a. ELVINS	INSIDE CITY LIMITS (SPECIFY YES OR NO) 7c. YES	HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) 7b. BARTON BOARDING HOME.		
STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY) 8. MO.	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) 10. WIDOWED	SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) 11. WILLIAM DIXON	
SOCIAL SECURITY NUMBER 12. 498-24-0067	USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) 13a. HOUSEWIFE	KIND OF BUSINESS OR INDUSTRY 13b. HOUSEWIFE.		
RESIDENCE—STATE COUNTY 14a. MO. ST. FRANCOIS	CITY, TOWN, OR LOCATION, ZIP CODE 14c. ELVINS 63639	INSIDE CITY LIMITS (SPECIFY YES OR NO) 14d. YES	TOWNSHIP 14e. RANDOLPH	STREET AND NUMBER 14f. 618 ETHEL ST.
FATHER—NAME FIRST MIDDLE LAST 15. TALLY M. BARTON	MOTHER—MAIDEN NAME FIRST MIDDLE LAST 16. MILL KATHERINE R. BARTON			
INFORMANT—NAME 17a. HAROLD G. DIXON		MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 17b. EAST MAIN ST. FLAT RIVER MO 63601		
PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. IMMEDIATE CAUSE (a) Medullary Failure DUE TO, OR AS A CONSEQUENCE OF:				2-3 days
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:				yes
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)				AUTOPSY (YES OR NO) 19a. NO
IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH 19b.				
ACCIDENT, SUICIDE, HOMICIDE OR UNDETERMINED (SPECIFY) 20a.	DATE OF INJURY (MONTH, DAY, YEAR) HOUR 20b. 24-7K TO 12 9 74	HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18) 20c.		
INJURY AT WORK (SPECIFY YES OR NO) 20d.	PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY) 20e.	LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE) 20g.	IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS 20h. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
CERTIFICATION—PHYSICIAN: I ATTENDED THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. 21a. DECEASED FROM 1 24-7K TO 12 9 74	MONTH DAY YEAR	AND LAST SAW HIM/HER ALIVE ON MONTH DAY YEAR 21c. 12 1 74	1. DID NOT VIEW THE BODY AFTER DEATH. 21d.	DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. 21e. 930A
CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. 22a.		HOUR OF DEATH 22b.		
THE DECEDENT WAS PRONOUNCED DEAD 22c.		MONTH DAY YEAR HOUR		
CERTIFIER—NAME (TYPE OR PRINT) 23a. FWZUSPAN	MO. LICENSE NO. 23b. 230546	SIGNATURE 23c. FWZUSPAN	DEGREE OR TITLE 23d.	DATE SIGNED (MONTH, DAY, YEAR) 23e. 12/11/74
MAILING ADDRESS—CERTIFIER 23a. 322 West main		CITY OR TOWN STATE ZIP 23b. Flat River MO 63601		
BURIAL, CREMATION, REMOVAL (SPECIFY) 24a. BURIAL	CEMETERY OR CREMATORY—NAME 24b. THREE RIVERS CEM.	LOCATION CITY OR TOWN STATE 24c. R.F.D. 2. FARMINGTON-MO.		
DATE (MONTH, DAY, YEAR) 24d. DEC-11-1974	FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 24e. CALDWELL FUNERAL HOME, 7-11E MAIN ST. FLAT RIVER-MO 63601.			
FUNERAL DIRECTOR—SIGNATURE 25b. Ray G. Caldwell	REG. NO. 25c. 686	REGISTRAR—SIGNATURE 25d. M.D. Day	DATE RECEIVED BY LOCAL REGISTRAR 25e. Dec. 14, 1974	

DEC 20 1974

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 David P. Caldwell

Licensed Embalmer No. 5184

P. O. Address Flat River, 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.