DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23102

Registration District No. 336
Primary Registration District No. 6128
Registrar's No.

1. PLACE OF DEATH:
(a) County: Shannon
(b) City or town: Eminence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital St. Louis, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Shannon 101
(c) City or town: Rural Eminence
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Opal Lola Dixon
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: John H. Dixon
6. (c) Age of husband or wife if alive: 43 years
7. Birth date of deceased: Feb (Month) 18 (Day) 1908 (Year)

8. AGE:	Years	Months	Days	If less than one day
	39	3	27	hr. min.

9. Birthplace: Gang (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Doc Goforth
13. Birthplace: Douglas Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Malissi Mooney
15. Birthplace: (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: John H Dixon
(b) Address: Eminence, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Bethyl Chapel
18. (a) Signature of funeral director: Duncan Funeral Home
(b) Address: Mountain View, Mo
19. (a) 5-20-47 (Date received local registrar) (b) Mobel Rose (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1947 hour 2 minute P.M.
21. I hereby certify that I attended the deceased from ______, 19__, to ______, 19__; that I last saw h___ alive on ______, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Carcinoma | Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature: Frank Hyde (M. D. or other)
Address: Eminence
Date signed: 5-14-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 64734
Date Filed 6-17-47

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 ....

............, Registered Apprentice No. ....

working under my personal supervision.

Not Embalmed

Signed Joe L. Duncan

Licensed Embalmer No. 4325

P. O. Address Mtn View, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 336 Primary Registration District No. 6128 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Eminence (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Shannon
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Eminence (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Opal Lola Dixon
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 18 1908 (Month) (Day) (Year)
8. AGE: Years 39 Months 3 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 7-8-47 (Date received local registrar) (b) Mabel Rollins (Registrar's signature) dep

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 4
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

23102