CAUSE OF DEATH in plain terms, so that it may be properly [illegible] very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39124

PLACE OF DEATH

County Polk

Township Mooney
or
Village
or
City (NO. St.: Ward)

Registration District No. 710 File No.

Primary Registration District No. 5939 Registered No. 17

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Albert Joy Dodd

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Jan. (Month) 26 (Day), 1870 (Year)

AGE: 46 yrs. 10 mos. 20 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

BIRTHPLACE (City or town, State or foreign country): Pulaski Como

PARENTS

NAME OF FATHER: F B Dodd

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pulaski Como Tenn

MAIDEN NAME OF MOTHER: Susan Hicks

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Tuckness

(ADDRESS) Van, Mo

Filed Nov 14, 1917. Claud H Slagle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 14 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 6, 1917, to Nov 14, 1917, that I last saw him alive on Nov 14, 1917, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 01 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. E. Albright M. D.

Nov 13, 1917 (Address) Pleasant Hope

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Pleasant Hope

DATE OF BURIAL: Nov 15, 1917

UNDERTAKER: W. T. Prater

ADDRESS: Pleasant Hope

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191....,

that I last saw h.....alive on ....., 191....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(Secondary)

.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS