

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

Do not use this space.

1929

12199

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Jefferson Barracks

Registration District No. 1123
Primary Registration District No. 6248 B

File No. _____
Registered No. 119
St. _____ Ward _____

2. FULL NAME

Walter L. Dozier
(a) Residence. No. 42-8 Jeff Bks. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF May Ella (nee Green)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 11, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 2 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Himself
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ronalds County
(STATE OR COUNTRY) Georgia

10. NAME OF FATHER Richard Tyler Dozier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Warren County
(STATE OR COUNTRY) Georgia

12. MAIDEN NAME OF MOTHER McDuff-Louisa Morris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) The Duffy County
(STATE OR COUNTRY) Ga.

14. INFORMANT Ms. O. F. Klayner
(Address) Jeff. Bks Mo.

15. FILED 3/22 1929 L. C. Obrock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 21st. 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1928 to Mar. 21st, 1929, to March 21st, 1929, and that I last saw him alive on March 21st, 1929 and that death occurred, on the date stated above, at 6-30 PM in _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appoplexy, cerebral
Muscular Atrophy, progressive
Progressive Mus. Atrophy (duration) 6 yrs. ___ mos. ___ da.

CONTRIBUTORY (SECONDARY) Senility, Apoplexy
Apoplexy (duration) ___ yrs. ___ mos. 7 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Georgia
DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Clinical observation

(Signed) W. C. Steel M. D.
Mar. 22nd. 1929 (Address) Jefferson Barracks, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Columbia Georgia
DATE OF BURIAL 3/25 1929

20. UNDERTAKER Chapman & Co.
ADDRESS 7814 1/2 Broadway

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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