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

Do not use this space.

14117

1. PLACE OF DEATH
County Cass Registration District No. 156
Township ~~Grand River~~ Primary Registration District No. 4090
City Harrisonville (No. ..... St. ..... Ward)

File No. .....
Registered No. 22

2. FULL NAME Jay Vern Dodds
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 6 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): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 27-1921

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
7	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work in school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cass County
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER William A. Dodds
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kansas
12. MAIDEN NAME OF MOTHER Beulah Hamilton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT W. A. Dodds
(Address) Harrisonville Mo.

15. FILED 4/25 1929 D S Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 23 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1929 to Apr. 22, 1929 that I last saw him alive on Apr. 23, 1929, and that death occurred, on the date stated above, at 6:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Whooping cough

..... (duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (SECONDARY) 9

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. S. Triplett, M. D.
, 19 (Address) Harrisonville, 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: Oakland
DATE OF BURIAL: 4/24 1927

20. UNDERTAKER: Runnenburger Bros & Co
ADDRESS: Harrisonville Mo

Dr Triplett

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.

261 — 2