

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

Do not use this space.

18528

**PLACE OF DEATH**

County Barry Registration District No. 5250  
 Township Shell Knob Primary Registration District No. 38  
 City Shell Knob (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2. FULL NAME Eliza J. Dodson  
 (a) Residence. No. \_\_\_\_\_ 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 Fe. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 5th. 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	75	10	2	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

10. NAME OF FATHER F. Hollingworth

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rebeka Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

14. INFORMANT T. A. Dodson  
 (Address) Shell Knob Mo.

15. FILED 6/26 1930 Emma Weddington  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-7th-1930 19

17. I HEREBY CERTIFY, That I attended deceased from 6/3/30 19, to 6/7/30 19, that I last saw h. EP alive on 6/3/30 19, and that death occurred, on the date stated above, at 6:30 P. m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
arterial sclerosis,  
& valvular disease of heart

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY rheumatica deformans.  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 7000

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED clinical  
 (Signed) [Signature] M. D.

, 19 (Address) Cassville, 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 Dudman Cemetery DATE OF BURIAL 6-8-30  
Sarcoxie Mo.

20. UNDERTAKER Horine Funeral Service ADDRESS Cassville

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.

18528  
 5-1-30

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