

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

Do not use this space.

16330

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 339
Primary Registration District No. 1002
(No. 2211 Holmes)

File No. _____
Registered No. 2123
St. _____ Ward _____

2. FULL NAME Annie Elsie Dodge

(a) Residence, No. 2211 Holmes St., _____ Ward, _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>James P. Dodge</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 9, 1870</u>		
7. AGE	YEARS	MONTHS
<u>62</u>		<u>1</u>
	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>17</u>	<u>5</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> <u>235</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 26, 32 19

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ind.

10. NAME OF FATHER Solman P. Winders

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) 31 Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not Known

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
WAS THERE AN AUTOPSY? Autopsy
3 WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) [Signature], M. D.
5/26, 1932 (Address) [Address]

*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.

14. INFORMANT Gertrude Burk
(Address) 2211 Homes

15. FILED May 27, 1932 M. M. Cerow REGISTRAR
[Signature]

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Freeman Ave DATE OF BURIAL May 27 1932

20. UNDERTAKER Wagner Funeral Home ADDRESS 204 N. Lincoln

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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