

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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County Howard  
Township Franklin  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 380  
Primary Registration District No. 5530

File No. 4735  
Registered No. 1

2. FULL NAME Henry W. Dodson

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_ (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 Maggie Dodson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 20-1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
-	<u>65</u>	<u>11</u>	<u>12</u>	

OCCUPATION - 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co. Mo

FATHER 13. NAME Wm Dodson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not attainable

MOTHER 15. MAIDEN NAME Mary Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not attainable

17. INFORMANT (ADDRESS) Frank Dodson, New Franklin, Mo. R.F.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cemetery DATE 4/3/34 19. \_\_\_\_\_

19. UNDERTAKER (ADDRESS) Le. D. Debra, New Franklin, Mo.

20. FILED 2-12- 1934 J. B. [unclear] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 26 1934 to Feb 2 1934

I last saw him alive on Jan 26 1934. Death is said to have occurred on the date stated above, at 8.06 a.m.

The principal cause of death and related causes of importance were as follows:

Myocarditis with hypertension  
830  
102

Date of onset
<u>years</u>

Other contributory causes of importance: Parents

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

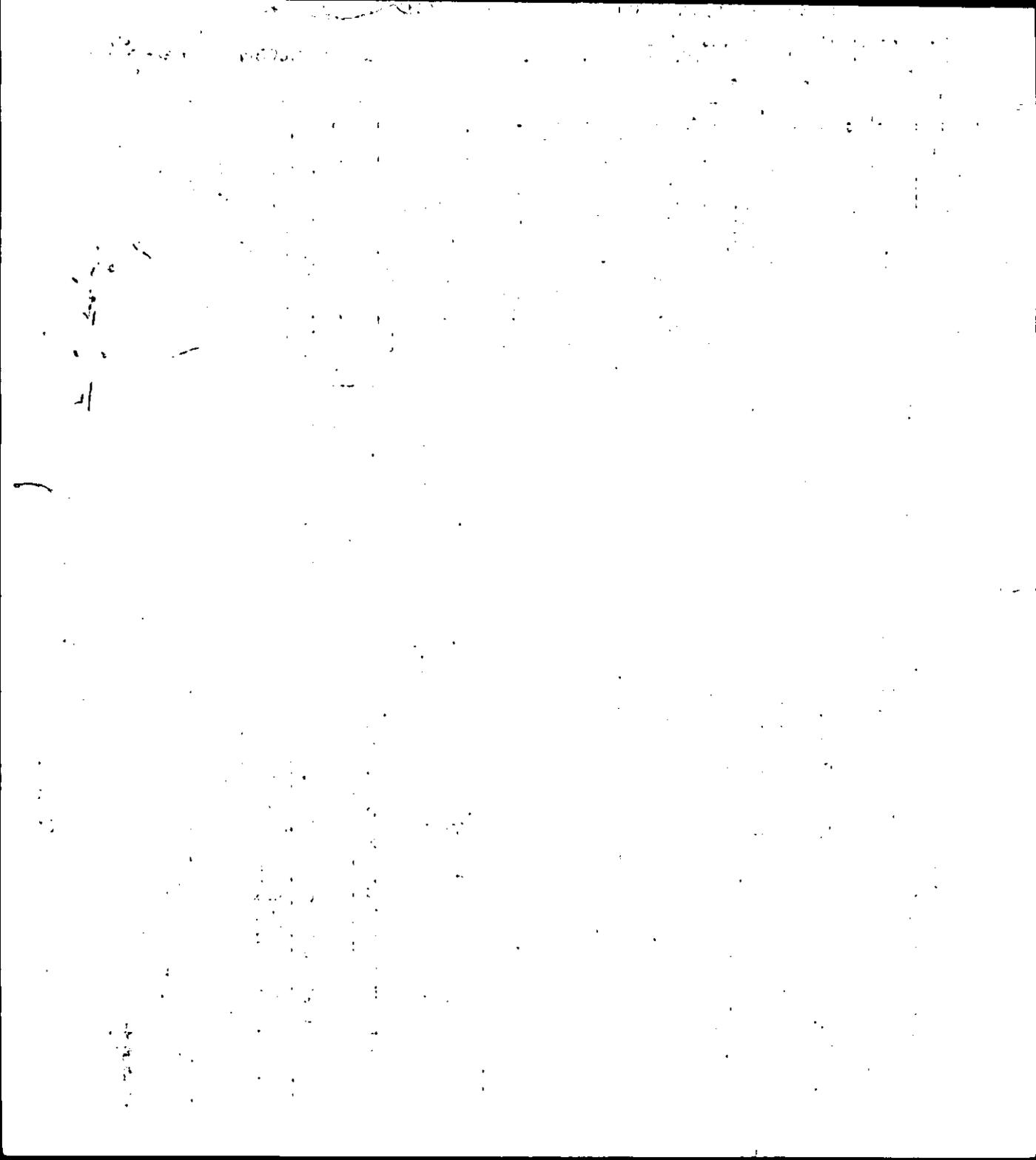
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_  
(Signed) Geo Schumacher M. D.  
(Address) Fayette Mo



New Franklin, Mo.,

November 4, 1934.

Dr. E. T. McGaugh, State Registrar,

Jefferson City, Mo.

Dear Doctor McGaugh:

When we received the inquiry referred to on opposite side we mailed it to Dr. Schumacher at Fayette with a note requesting him to fill in the desired information and mail it direct to you in your return envelope which we enclosed. We heard nothing from him so supposed he did it.

We have tried to get in touch with him but find that he has gone from Fayette and is now in St. Louis and we have been unable to get his address.

Yours truly,

J. B. Fleet, M.D.  
Local Registrar  
Bar. C. W. H.

unable to locate  
attending Physician  
use as Supplementary

Howard Co  
Dr. J. B. Fleet  
New Franklin, Mo

OCT 30 1934

Local Registrar:

We are holding certificates for which we have mailed you supplemental blanks, asking that certain information be supplied, so that we may complete our records. This information is needed to complete our transcripts for the Census Department at Washington, D. C.

It is the duty of the Local Registrar to secure all information asked for by the Department.

You are holding Supplements for the following ~~persons~~

February - 4735 - Miriam W Dodson

S-4735(2)

4735

*Howard*

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Hermon W Dodson*  
Who died at \_\_\_\_\_ on *Feb 2 - 1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex *m* Color or race *w* Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *65* Months *11* Days *12*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: *myocarditis with hypertension* Month \_\_\_\_\_ Year \_\_\_\_\_  
Birthplace (State or country) \_\_\_\_\_  
Birthplace of father (State or country) \_\_\_\_\_  
Birthplace of mother (State or country) *Parents*  
Principal cause of death: *(No further information obtainable)*

Other contributory causes of importance \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
If death was due to external causes (violence) fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
Name of physician *C. W. Schumacher*  
Address of physician *Fayette Ma*  
Signature of Registrar *[Signature]* Date filed \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *380*

Very truly yours,  
*E. T. McGaugh*

Primary Reg. Dist. No. *5530*

State Regis *12*  
Special Agent.

S 4735 (2)

S 4735 (2)