

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.

REC'D JUN 8 1939

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

19703
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Clayton Primary Registration District No. 101 Registered No. 941
 (c) City Clayton (d) Street No. St. Louis County Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Dodson
 (a) Residence, No. Chambers & Alma, Riverview Gardens, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 Katherine Dodson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 30, 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	64	3	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil.

9. Industry or business in which work was done, as 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) Mo.

FATHER

13. NAME Francis Dodson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

MOTHER

15. MAIDEN NAME Louisa Williams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT wife, Katherine Dodson
 (ADDRESS) Chambers & Alma, Riverview Gardens

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Memorial Park DATE May 26, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edith E. Anderson
4234 Washington Ave St. Louis

20. FILED May 24, 1939 R. R. Meyer, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-23-39 19..

22. I HEREBY CERTIFY, That I attended deceased from 5-22-39, 19.., to 5-23-39, 19..
 I last saw him alive on 5-23-39, 19.. Death is said to have occurred on the date stated above, at 4:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
+ myocardial degen. 1 yr +

Date of onset

Other contributory causes of importance:
Hypertension 930

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

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?

If so, specify

(Signed) a. a. Bremer, M. D.
Co. Hosp.

(Address) 707

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.