

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.

SEP 1939

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

29629
Do not use this space.

1. PLACE OF DEATH
(a) County Macon Registration District No. 533
(b) Township Macon Primary Registration District No. 3027
(c) City Macon (d) Street No. _____ 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 Molly Dodd
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) No Record
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
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) Dix
13. NAME OK No Family
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK Record
15. MAIDEN NAME OK
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK
17. INFORMANT Susie Trice
(ADDRESS) Macon, Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Woodlawn Cem DATE 8-2-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stephens Woodding
Macon, Mo.
20. FILED 9/7 1939 Sister Keenan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31, 1939
22. I HEREBY CERTIFY, that I attended deceased from July 31, 1939
Dr to July 31, 1939
I last saw her alive on July 28, 1939 at 7:30 a.m. Death is said to have occurred on the date stated above, at _____ a.m.
The principal cause of death and related causes of importance were as follows:
Cerebral Arterio sclerosis Date of onset 1925
97
Other contributory causes of importance:
Grand Arterio Sclerosis 1925
Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No
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) J F Turner, M. D.
(Address) Macon, Mo.

RECEIVED

District Health Officer No. 10

District File Number 9-39-1634

Date Filed SEP 11 1939

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 C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo.

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

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