

Registration District No. 716 **MAR 11 1940**

Primary Registration District No. 5945

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Pulaski County
 (b) City or town Crocker Mo.
 (c) Name of hospital or institution: St. Luke's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Eight weeks
 In this community all life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Amanda Jane Dodd 36 1/2

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife J. A. Dodd Age of husband or wife if alive ✓ years

7. Birth date of deceased April 2 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 24 If less than one day hr. _____ min.

9. Birthplace Pulaski County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Joseph H. Turpin

18. Birthplace Pulaski County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Tennessee Anderson

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Turpin

(b) Address Crocker Mo.

17. (a) Burial (b) Date thereof Feb 28 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crocker Mo.

18. (a) Signature of funeral director I. L. WOODS & SONS

(b) Address Crocker Missouri 1104 1/2

19. (a) Feb 29/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski
 (c) City or town Crocker, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26
 year 1940 hour 10 minute 0 A. M.

21. I hereby certify that I attended the deceased from February 27
77 Feb. 1940 to Feb 26, 1940

that I last saw her alive on February 25, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
of heart Duration One hour

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Cerebral hemorrhage

Of operations None

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? ✓ (Specify type of place) (e) Means of injury ✓

28. Signature [Signature] (M. D. or other) MD

Address Crocker Mo. Date signed 2/28/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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. 1-1-27

RECEIVED

District Health Officer No. 8,

District File Number 340271

Date Filed 3840

Signed Paul B. Hooper

Licensed Embalmer No. 3261

P. O. Address Bryant, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 12090
Registrar's No. 8

Registration District No. 716

Primary Registration District No. 3945-

1. PLACE OF DEATH:

(a) County Pulaski Co
(b) City or town Crocker Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Lukes, St Louis Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution
In this community Bed in Crocker Mo (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Amanda Jane Dodel

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 24 If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Feb 29/40 (b) W. J. Bell (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29 1940
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature W. J. Bell (M. D. or other)!

Address Crocker Mo Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1940
S-12090