

No. 4-13-17 X23155

FILED SEP 24 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27860

Registration District No. 40

Primary Registration District No. 4024

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Barton

(b) City or town Lamar
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Dovie Stodhard 336

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 2nd, 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

62 6 25 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Claude Mitchem

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

14. Maiden name Alberta Wood

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

16. (a) Informant Hospital # 3 record

(b) Address Nevada, MO.

17. (a) Burial (b) Date thereof 8-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada, MO.

18. (a) Signature of funeral director River Funeral Home

(b) Address Lamar, MO.

(a) Aug 28-1940 (b) Mrs. Josephine Myrtle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon

(c) City or town Nevada
(If outside city or town limits, write "RURAL")

(d) Street No. State Hospital #3
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27th
year 1940 hour 4 minute P. 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 Fracture of Right side of head - malum bone extending into Rt frontal region

Due to also fracture of Rt leg above knee

Due to Automobile wreck on Highway 71 - about 4 miles north of Lamar, Mo.

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

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? 40

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

28. Signature C. E. Ducicatt (M. D. or other) MD.

Address Lamar, Mo. Date signed Aug 28

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

RECEIVED

District Health Officer No. 67

District File Number 940-2624

Date Filed SEP 18 1940

210M
56
95

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 do the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.