

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

Rev. 6-17-39
Form 1 X9511

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.

OCT 10 1940
Registration District No. 316

Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME LUCIA DODGE
3. (b) If veteran, name war NO
3. (c) Social Security No. None

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ESTON DODGE
6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased OCTOBER 9 1907
(Month) (Day) (Year)

8. AGE: Years 32 Months 11 Days 4
If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business 9

MOTHER FATHER { 12. Name Jesse ABLES

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

14. Maiden name LORENA CRITES

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

16. (a) Informant's own signature ESTON DODGE

(b) Address BOLIVAR MO

17. (a) BURIAL (b) Date thereof 3 SEPT 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALEM CEMETARY

18. (a) Signature of funeral director HITCHESON + CO

(b) Address BOLIVAR MO

19. (a) Sept. 15, 1940 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County POH K
(c) City or town BOLIVAR, RURAL
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month SEPT day 13
year 1940 hour 9 minute 35 P. M.
21. I hereby certify that I attended the deceased from Aug 14, 1940 to Sept 13, 1940;
that I last saw her alive on Sept. 13 and that death occurred on the date and hour stated above.

Immediate cause of death Septic Pneumonia Duration 15 days
T. Myocardial degeneration 10 days
Due to Toxemia of Pregnancy
with placenta previa
Due to _____
Other conditions Caesarean section
(Include pregnancy within 3 months of death)

Major findings: Placenta Previa with Transverse separation
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 _____
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 Joseph S. Lawes (M. D. or other) MD
Address Springfield Mo Date signed _____

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.

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