

FILED MAR 17 1941

Registration District No. **400**

Primary Registration District No. **655319**

Registrar's No. **29**

48
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Jackson County Homeopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 hrs 8 days
(Specify whether)

In this community 55 Year
years, months or days

8. (a) PRINT FULL NAME Smith B. Dodson

8. (b) If veteran, name war ✓

8. (c) Social Security No. ✓

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w 2

6. (c) Age of husband or wife if alive years 2

7. Birth date of deceased June 30 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>7</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation Plasterer

11. Industry or business ✓

MOTHER FATHER

12. Name W. H. Mc Carthy

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

14. Maiden name W. Va.

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

16. (a) Informant W. H. Mc Carthy

(b) Address Little Blue, Mo.

17. (a) Burial, cremation, or removal Burial

(b) Date thereof 2-9-41
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. A. E. Foster

(b) Address 918 Brooklyn

19. (a) 2-9-41 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 4221 Balescare
(If rural, give location)

(e) If foreign born, how long in U.S. A. 8 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1941 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 1-1941
to July 7-1941
that I last saw him alive on July 7-1941
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis chronic

Due to 93A

Due to 93A

Other conditions Hypertension
(Include pregnancy within months of death)

Major findings and Senile Dementia

Of operations _____

Of autopsy _____

Duration

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? _____

23. Signature [Signature]
(Name of physician)

Address Little Blue, Mo.
(City or town) (State)

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 Ronald J. Wade

Licensed Embalmer No. 4172

P. O. Address Kansas City

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.