

X21492

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

DEPARTMENT OF COMMERCE
RECEIVED APR 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10327

Registration District No. 136

Primary Registration District No. 5219

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Grand River Dist.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lucy Harding Hospital
(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) Billy Duane Dobson

3. (a) PRINT FULL NAME: Infant Son of Orley Elizabeth Dobson
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mon 8 1941
(Month) (Day) (Year)

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

9. Birthplace Harrisonville, Mo - Rural
(City, town, or county) (State and country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Orley Dobson
13. Birthplace Peculiar Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Brown
15. Birthplace Santa Fe New Mexico
(City, town, or county) (State or foreign country)

16. (a) Informant Orley Dobson
(b) Address Rt. 2 Harrisonville, Mo.

17. (a) Rural (b) Date thereof 3 9 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wills Cemetery
18. (a) Signature of funeral director RUNNENBURGER'S
(b) Address HARRISONVILLE, MO.

19. (a) 3/9/41 (b) X
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Peculiar Twp.
(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 March day 8
year 1941 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from March 8, 1941, to March 8, 1941;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia neonatorum Duration _____

Due to second twin, prolaps
vesicula

Due to _____
Other conditions 1600
(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? 845

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

23. Signature Pedunley M.S. (M. D. or other) _____
Address Harrisonville Date signed 4/1/41

NOV 13 1956

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.

Not embalmed

Signed: _____

Licensed Embalmer No. _____

P. O. Address _____

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

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

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10327

Registration District No. 156

Primary Registration District No. 5219

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Grand River T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) Infant son of Orley & Elizabeth Dobson
FULL NAME
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) March 9, 1941 (b) J. Beckley, M.D.
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 8
year 1941 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 _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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?

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

23. Signature H. H. Harrison, M.D. (M. D. or other)

Address Harrisonville, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-10327 1941

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 the above constitutes grounds for revocation of license.)

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