

Registration No. **713**

Primary Registration District No. **5942**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Pulaski**
 (b) City or town **Rural Between Crocker and Waynesville, Mo.**
 (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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Butler**
 (c) City or town **Malden**
 (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 _____

3. (a) PRINT FULL NAME **Grady L. Dowdy**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **3rd**
 year **1941** hour _____ minute _____ M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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.

7. Birth date of deceased **NOV 26 1918**
 (Month) (Day) (Year)

Immediate cause of death **Skull fracture through spine with hemorrhage**
 Due to _____
 Due to _____

8. AGE: Years **22** Months **7** Days **7** If less than one day _____ hr. _____ min.

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

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

10. Usual occupation **Soldier**
 11. Industry or business **U.S. Army**
 12. Name **UNKNOWN DOWDY**
 13. Birthplace **UNKNOWN**
 14. Maiden name **MARY UNKNOWN**
 15. Birthplace **UNKNOWN**

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **U.S. Army Records**
 (b) Address **Fort Leonard Wood, Mo.**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **D.B.S.**
 (b) Date of occurrence **July 3rd 1941**

17. (a) **Removal** (b) Date thereof **July 5th '41**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Malden, Missouri**

(c) Where did injury occur? **Public Place Hy 17**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

18. (a) Signature of funeral director **John Clark**
 (b) Address **Rolla, Mo.**

While at work? **No** (Specify type of place) **Auto**
 (e) Means of injury

19. (a) **7/4/41** (b) **C. A. Gentry**
 (Date received local registrar) (Registrar's signature)

23. Signature **A. N. Graham** (M. D. or other) **MD**
 Address **Ft. Leonard Wood, Mo** Date signed _____
Station Hospital

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

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.....

Low H. Clark

Licensed Embalmer No. *4216*

P. O. Address *Rolla, 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, fact should be so stated above.

Registration District No. 713

Primary Registration District No. 5942

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pulaski
 (b) City or town _____
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

Grady L. Dowdy

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 alive _____ years

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(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 July 3 day 3 year _____ hour 10 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 Skull fracture through Sphenoid to Hypophyseal Sella area with hemorrhage
 Due to Auto accident which occurred when car in which he was riding overturned after getting on soft shoulder of Highway 7 (at the maintained 2 mile south of Crocker, Mo.
(Exclude pregnancy within 3 months of death)
no other auto or vehicle involved

Duration _____

Other conditions _____
 Major findings: _____
 Of operations _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Of autopsy Skull fracture thru Sphenoid & Hypophyseal area, hemorrhage into Cava & Medulla

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

(a) Accident, suicide, or homicide (specify) Auto accident

(b) Date of occurrence July 3, 1941

(c) Where did injury occur? Highway 7, 2 miles south of Crocker, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Maintained Highway 7, 2 miles south of Crocker, Mo.
(Specify type of place)

While at work? no (e) Means of injury Automobile

23. Signature J. H. Graham (M.D. or other) M.D.

Address 805 7th St., A.P.O. #6-6 Date signed 8-25-41

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

SUPPLEMENT

176

Camp Roberts Ark.

S-22462

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.