

S. No. 2
M-1-4-41
v. 5-17-39
X26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24990

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registration District No. _____

Primary Registration District No. 282-4166

Registrar's No. 28

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

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1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Campbell, Mo.
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community most of life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin ⁰³⁵
(c) City or town Campbell Mo ⁰
(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 — ⁰

3. (a) PRINT FULL NAME Charley H. Doser
(b) If veteran, name war —
(c) Social Security No. 498-09-9164

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 12th
year 1941 hour 10 minute 15 A.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Jessie Doser
(c) Age of husband or wife if alive 35 years
7. Birth date of deceased: Sept 2 1905
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 10 1941 to Aug 12 1941
that I last saw him alive on Aug 10 1941
and that death occurred on the date and hospital stated above.
Immediate cause of death acute lung ^{Duration}

8. AGE: Years 35 Months 11 Days 10
If less than one day hr. _____ min. _____

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

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

10. Usual occupation Labor

11. Industry or business Labor

12. Name John Doser

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

14. Maiden name Maie White

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

16. (a) Informant Maie Doser
(b) Address Campbell Mo.

17. (a) Burial (b) Date thereof Aug 13, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wood Lawn

18. (a) Signature of funeral director London James
(b) Address Campbell Mo.

19. (a) Aug-12-41 (b) London James
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____
23. Signature John L Brown (M. D. or other) —
Address Campbell Mo Date signed Aug 11

AUG 25 1944

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 *Christina M Landess*

Licensed Embalmer No. *4227*

P. O. Address *Campbell, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24990
Registrar's No. 28

Registration District No. 472 Primary Registration District No. 282

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

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Campbell
(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)

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 _____

3. (a) PRINT FULL NAME Charley A Doser
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 19 year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

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

Due to Plural tubercles
Due to _____
Other conditions _____ (include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy 110a

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/17/41 (b) [Signature]
(D file received local registrar) (Registrar's signature)

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)
(b) 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 John L Brown (M. D. or other) _____
Address Campbell mo Date signed 24. 1941

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

SUPPLEMENTARY

S-24990