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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25288

Registration District No. 408 | Primary Registration District No. 3020 | Registrar's No. 111

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

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 603 East Macon St.,
(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)
In this community Fifty Three Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 603 East Macon St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rebecca Jane Dodwell
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James W. Dodwell
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 26, 1849 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
92	0	27	hr. min.

9. Birthplace Sincoe, Canada (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Isaac DeCou
13. Birthplace Canada (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Frances Dunmeeds
15. Birthplace Canada (City, town, or county) (State or foreign country)
16. (a) Informant Miss Leona Dodwell
(b) Address 603 East Macon St., Carthage
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-41 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery
18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address 1208 S. Garrison, Carthage, Mo.
19. (a) July 24, 1941 (Date received local registrar) (b) E. J. McIntire, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23, year 1941 hour 9:30 minute P. M.
21. I hereby certify that I attended the deceased from June 25, 1941, to July 23, 1941, that I last saw her alive on 23 de July, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Senility	
Due to	
Other conditions (Include pregnancy within 3 months of death) Bed patient 8 years	
broken at hip	

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 E. D. Hatcher (M. D. ~~other~~)
Address 403½ S. Main, Carthage Date signed July 24 '41

(Licensed Embalmer's Statement on Reverse Side)

41-8-706

SEP 2 2 1945

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.....2222

P. O. Address.....Carthage

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

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

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

403½ S Main, Carthage

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: 603 E. Macon St
(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 Rebecca J. Dodwell

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

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. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER
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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1941 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw h..... alive on ..... 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Senility 186a 14

Due to .....

Other conditions Bed patient 8 years
(Include pregnancy within 3 months of death)
Broken rt. hip

Major findings:
Of operations A fall in her home, on floor.
Of autopsy No 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) 8
(b) Date of occurrence 8 years ago in July
(c) Where did injury occur? At her home (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)
While at work? Yes (c) Means of injury fall on floor

23. Signature E D Hatcher (M. D. or other)
Address Carthage Date signed 9/17/41

S-25288