

FILED AUG 29 1944

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 208

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Keokuk Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Laughlin Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

Joseph Sheldon Dodd

3. (b) If veteran, name war no 3. (c) Social Security No. —

4. Sex Male 5. Color or race w 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Eva Dodd 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased May 29 - 1856  
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name John Dodd

13. Birthplace N. Car. Mo. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Aracyn Adams

15. Birthplace Not known 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eva Dodd  
(b) Address Adair Mo

17. (a) Burial (b) Date thereof July 17 - 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Garrett Cemetery

18. (a) Signature of funeral director W. L. Miller - Backalen

(b) Address Shelby Mo

19. (a) July 15, 44 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shelby  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15  
year 1944 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 13 1944 to July 15 1944;  
that I last saw him alive on July 15 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Premia

Due to Enlargement of Prostate

Due to \_\_\_\_\_  
Other conditions Hemiplegia (Rt) 18 stroke 7-5-44  
(Include pregnancy within 3 months of death) 2 7-13-41

Major findings:  
Of operations   
Of autopsy   
PHYSICIAN JSD  
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? \_\_\_\_\_

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

23. Signature Earl Laughlin (M. D. or other) J.D.O.  
Address Keokuk, Mo Date signed 7-15-44

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

2  
41  
39

26330

1

RECEIVED

District Health Officer No. 10

District File Number 8-4-1583

Date Filed AUG-21-1941

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..... *C. W. Hawke*

Licensed Embalmer No. 3498

P. O. Address..... *Bethel Me.*

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.