

FILED MAR 12 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7510

State File No.

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 20

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

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rolla *town*

(c) Name of hospital or institution: Mc Farland Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months

(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME James David Dodd

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

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

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sarah Ellen Dodd

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 26th 1867

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>9</u>hr.min.

9. Birthplace Crawford County Missouri

(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business.....

12. Name Jesse Dodd

13. Birthplace Petersburg Tenn

(City, town, or county) (State or foreign country)

14. Maiden name Sarah Walls

15. Birthplace Petersburg Tenn

(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Dodd

(b) Address 2745 A Eads Ave., St. Louis, Mo.

17. (a) Burial (b) Date thereof Feb. 8th, 1942

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lick Creek Cem. Cuba Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Cuba, Missouri

19. (a) 2-7-42 (b) [Signature]

(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. Benton Township

(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5

year 1942 hour 10 minute 19 A.M.

21. I hereby certify that I attended the deceased from Dec 7th 1941, to 2-5 1942 that I last saw him alive on 2-5 1942 and that death occurred on the date and hour stated above.

Immediate cause of death General paralysis

Ravages of old age

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of 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).....

(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 [Signature] (M. D. or other) [Signature]

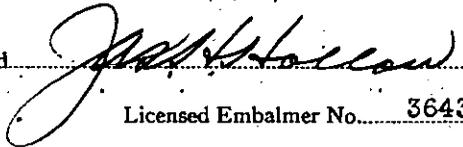
Address Rural Mo Date signed 2-6-42

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..... 3643

P. O. Address..... Cuba, Missouri

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.

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

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Gallatin
(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)

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

James A. Dodd

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

w

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

Apr 26 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>7</u>	<u>7</u>	hr. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry of business

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day _____ year 1942 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 _____

Due to Stages of old age Myocarditis (chronic)

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of 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) _____
(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)
(a) Means of injury _____
23. Signature Edmund H. Fortney _____ (Date received local registrar) _____ (Registrar's signature) _____ Address _____ Date signed _____

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. (a) Informant

(b) Address

17. (a) _____ (Burial, cremation, or removal)

(b) Date thereof

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) _____ (Date received local registrar)

(b) _____ (Registrar's signature)

