

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12464

State File No.

Registrar's No. 65

Registration District No. 378

Primary Registration District No. 6285

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain Grove (Rural)
(c) Name of hospital or institution: MA MOUNTAIN GROVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 34 years
(Specify whether years, months or days)

3. (a) PRINT Elwin Lester Dawson
FULL NAME

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 single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased March 16 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 10 26 hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Moses P. Dawson
13. Birthplace Morgan County Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Amy Moore Newton
15. Birthplace Athens County Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Daisy Dawson
(b) Address Mountain Grove Mo

17. (a) Burial (b) Date thereof 2/14/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hill Crest Cemetery

18. (a) Signature of funeral director George Stapp

(b) Address Mountain Grove Mo

19. (a) 2/14/1944 (b) H. M. Lawen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright
(c) City or town Mountain Grove (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 Feb. day 12
year 1944 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from 2/6 1944 to 2/11 1944
that I last saw him alive on Feb 11
and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack
8 B. Ramm

Due to.....

Due to.....

Other conditions Chronic
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 W. H. H. H. H. (M.D. or other)
Address W. H. H. H. H. Date signed 2/21

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 6
District File Number 344-301
Date Filed MAR 14 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

George Stapp

Licensed Embalmer No.

3161

P. O. Address

Mtn. Home Rd.

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.