

FILED MAY 9 1944

State File No. _____

Registration District No. 9344

Primary Registration District No. 4154

Registrar's No. 29

1. PLACE OF DEATH:
 (a) County DADE
 (b) City or town GREENFIELD
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
So. MAIN ST. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NONE
 (Specify whether years, months or days)
 In this community 80 YEARS

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County DADE 39
 (c) City or town GREENFIELD
 (If outside city or town limits, write "RURAL")
 (d) Street No. So. MAIN ST.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country NONE

3. (a) PRINT FULL NAME JOHN L. DODSON
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month APRIL day 14
 year 1944 hour 7 minute 9 M.

4. Sex MALE
 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive ✓ years _____
 7. Birth date of deceased SEPTEMBER 20 1863
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 10 1944 to April 14 1944
 that I last saw him alive on April 13 1944
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>6</u>	<u>24</u>	_____br. _____min.

Immediate cause of death Uremia
 Due to Chronic nephritis
 Due to _____

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

Other conditions fractured right femur 12/1/44
 (Include pregnancy within 3 months of death)

10. Usual occupation FARMER
 11. Industry or business AGRICULTURE

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death is charged statistically.

MOTHER FATHER
 12. Name WILLIS G. DODSON
 13. Birthplace No RECORD 9
 (City, town, or county) (State or foreign country)
 14. Maiden name MARTHA B. SPIVES
 15. Birthplace No RECORD 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Shua Dodson
 (b) Address Greenfield Mo.
 17. (a) BURIAL (b) Date thereof 4-16-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation DADEVILLE MASONIC

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 _____

18. (a) Signature of funeral director Ward Funeral Home
 (b) Address Greenfield, Mo.
 19. (a) 4-18-44 (b) Phyllis Lack
 (Date received by local registrar) (Registrar's signature)

23. Signature W. H. ... (M. D. or other) P.O.
 Address Greenfield, Mo. Date signed 4/18/44

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

RECEIVED

District Health Officer No. 6,

District File Number 544-520

Date Filed MAY 4 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

Sam E. Perseney Jr.

Licensed Embalmer No. 4099

P. O. Address

Greenfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mo
Registrar's No. 291

Registration District No. 93 Primary Registration District No. 4154

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

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Greenfield
(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)

3. (a) PRINT FULL NAME John J. Dodson
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.....

7. Birth date of deceased Sept. 20
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days..... (If less than one day..... min.)

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

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) (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)

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.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April year 1944 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 Uremia

Due to.....
Due to.....

Other conditions.....
(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) Accident
(b) Date of occurrence 1/22/44
(c) Where did injury occur? Greenfield Dade, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - For aged people.
While at work? no (Specify type of place) (e) Means of injury Fall.

23. Signature J. D. Shannon (M.D. or other) P.O.
Address Greenfield Mo Date signed 4/24/44

SUPPLEMENTARY

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

14525