

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11150
State File No. _____
Registrar's No. 3442

FILED APR 27 1945
318

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hours
(Specify whether _____)

3. (a) PRINT FULL NAME Amanda Dadds
3. (b) If veteran, name war NIL
3. (c) Social Security No. NONE

4. FEMALE! 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BEN F. DODDS
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased MARCH 16 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER {
12. Name UNKNOWN
13. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)
14. Maiden name AMANDA VAUGHN
15. Birthplace IBERIA MO. D
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. J. F. LEONBERGER
(b) Address 5896 ENRIGHT AVE

17. (a) BURIAL (b) Date thereof 4-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DIXON, MISSOURI

18. (a) Signature of funeral director ALBERT W. HOPPE

(b) Address 4702 WASHINGTON

19. (a) APR 18 1945 (Date received local registrar)
J. P. Braddock (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County PULASKI
(c) City or town DIXON
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) NR
(e) Citizen of foreign country? ! (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 16
year 1945 hour 6 minute 15 P. M.
21. I hereby certify that I attended the deceased from April 16, 1945
to 4/16/45, 1945.
that I last saw her alive on 4/16/45, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____
peripheral vasc. collapse
coronary occlusion

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy Coronary occlusion

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 J. P. Braddock (M. D. or other)
Address Barnes Hospital Date signed 4/17/45

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

Albert G. Mapp

Licensed Embalmer No. 2971

P. O. Address.....

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.