

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14041**

Registration District No. **274**

Primary Registration District No. **3052**

Registrar's No. **128**

1. PLACE OF DEATH:

(a) County **PETTIS**
(b) City or town **SEDALIA**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **BOTHWELL HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7-DAYS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **HENRY**
(c) City or town **WALTON WALKER**
(If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HELENA DOLL**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **JOHN DOLL** 6. (c) Age of husband or wife if alive **DEAD 58**

7. Birth date of deceased: (Month) **Feb** (Day) **23** (Year) **1870**

8. AGE: Years **76** Months **1** Days **28** If less than one day hr. min.

9. Birthplace: (City, town, or county) **OHIO** (State or foreign country) **1**

10. Usual occupation **RETIRED**

11. Industry or business _____

MOTHER { 12. Name **JOHN BARTH**

13. Birthplace **GERMANY** (City, town, or county) (State or foreign country) **4**

14. Maiden name **MARY LEBOWITZ**

15. Birthplace **OHIO** (City, town, or county) (State or foreign country) **1**

16. (a) Informant **Ray Doll** (b) Address **Sedalia MO**

17. (a) **Remains** (b) Date thereof **4-23-46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **White Oak Cem**

18. (a) Signature of funeral director **H. A. Dausant** (b) Address **Sedalia MO**

19. (a) **4-21-46** (b) **Betty Yeager** (Date received local registrar) (Registrar's name) (City)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr 21** day **46** year _____ hour **6** minute **30** P.M.

21. I hereby certify that I attended the deceased from **Apr 14-46** to **Apr 21-46** that I last saw him alive on **Apr 21 46** and that death occurred on the date and hour stated above.

Immediate cause of death **H. Cerebral Hemorrhage & Pneumonia**

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death) _____

Major findings: Of operations **gsw**

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? _____

(Specify type of place) While at work? (e) Means of injury **0**

23. Signature **J. M. [unclear]** (M. D. or other) _____

Address **Sedalia MO** Date signed **4/21/46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 5-14-46

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 W. J. Causant.....

Licensed Embalmer No. 3779.....

P. O. Address Clinton.....

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.