

No. 2
-12-45
5-17-39
1 X47070

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

State File No. _____

Registrar's No. 2486

Registration District No. 316

Primary Registration District No. 1003

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:
Alexian Brothers Hospital

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

(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town St. Louis Lemay 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. 618 Kayser (If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Homer A. Dodson

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 489-05-0932

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Laura M.

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased November 15th, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56	4	16	hr. _____ min.
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9. Birthplace Otterville, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business _____

12. Name Junius Dodson

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Emma Compton

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Laura M. Dodson

(b) Address 618 Kayser, Lemay, Missouri

17. (a) Cremation (b) Date thereof Apr. 3, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valshalla Chapel of Memories

18. (a) Signature of funeral director Wacker-Helder W. K. C.

(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) APR 2 1947 (b) g. J. Bredish
(Date received local report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st
year 1947 hour 5 minute 00 P.M.

21. I hereby certify that I attended the deceased from Mar. 26th, 1947 to March 31st, 1947
that I last saw him alive on March 30th, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage (Left side) 83 4 days

Due to _____

Due to _____

Other conditions: Chr. Arteriosclerosis 6 mo.
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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 0

23. Signature W. H. Walters (M. D. or other) _____

Address 3608 S. Grand Blvd. Date signed 4/1/47

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 Robert Cochran
Licensed Embalmer No. 2178
P. O. Address St Louis 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 4941Registration District No. 918Primary Registration District No. 1003Registrar's No. 3486

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:

(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 NAMEHarriet G. 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.....
- m

6. (b) Name of husband or wife.....
-
6. (c) Age of husband or wife if
-
- alive.....

7. Birth date of deceased.....
- nov
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-
- 56
- hr. min.

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

10. Usual occupation

11. Industry or business

- MOTHER FATHER { 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)..... (b) Date thereof.....
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)
- 4-2-1947
- (b)
- J. J. Bredeck
-
- (Date received local registrar) (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.....
-
- year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
-
- to..... 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.....

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).....
 (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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

APR 21 1947

10750