V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 24 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35667

Primary Registration District No. 1003

Registrar's No. 9324

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0
City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 DAYS (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3411 Eads Ave. 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME LUCIAN H. DODSON

3. (b) If veteran, name war Nil

3. (c) Social Security No. 488-20-9435

4. Sex M 0

5. Color or race W

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 October 4, 1867 (Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 3 If less than one day hr. min.

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

10. Usual occupation Waiter

11. Industry or business

MOTHER FATHER

12. Name John M. Dodson

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

14. Maiden name Elizabeth Owen

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

16. (a) Informant Homer C. Dodson

(b) Address 15013 Coyle, Detroit, Michigan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-47 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) OCT 8 1947 (Date received local registrar) (b) J. F. Fredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 7 year 1947 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from OCTOBER 3 19 47 to OCTOBER 7 19 47 that I last saw him alive on OCTOBER 7 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage, subarachnoid and intraventricular, left	4 days
Due to Hypertensive vascular disease	1 year
Due to Arteriosclerosis, cerebral and generalized	

Other conditions (Include pregnancy within 3 months of death) Hemorrhage, subarachnoid and intraventricular, left, Hypertensive vascular disease, arteriosclerosis cerebral and generalized.

Major findings of operation

Of autopsy

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 0

23. Signature Warren B. Mills M. D. (M. D. or other)

Address 1515 Lafayette Av. Date signed 10-7-47

(Licensed Embalmer's Statement on Reverse Side)

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2301 Lafayette

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.