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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 29 1947

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 38106

Registration District No. 799 — Primary Registration District No. 1002 — Registrar's No. 4834

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days (Specify whether
In this community 44 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")
(d) Street No. 3721 Woodland 8 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Dozier
3. (b) If veteran, name war No
3. (c) Social Security No. 496-10-0017
4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Birdie M. Dozier
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased July (Month) 4, (Day) 1875 (Year)

8. AGE: Years 72 Months 4 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
10. Usual occupation General Contractor
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)
16. (a) Informant Jack C. Dozier
(b) Address 3721 Woodland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills
18. (a) Signature of funeral director Earp & Sons
(b) Address 4139 East 15th Street
19. (a) 11-19-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th year 1947 hour 8 minute 00 A.M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw I ..... alive on ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Acute Cerebral Encephalomalacia
Due to Cerebral Arteriosclerosis
Due to Chronic
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 83C
Of autopsy above

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature [signature] (M. D. or other)
Address St. Joseph Hospital Date signed 11 20 47

Jefferson City Printing Co. (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.....

Licensed Embalmer No.....

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.**