

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

FILED NOV 25 1947

Registration District No. 50

Primary Registration District No. 4239

Registrar's No. 187

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Lees Summit  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
102 Oak Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 10yr  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson <sup>48</sup>

(c) City or town Lees Summit  
(If outside city or town limits, write "RURAL")

(d) Street No. 102 Oak Street  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Henry Dodson

3. (b) If veteran, name war No

3. (c) Social Security No. 495-01-9668

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10  
year 1947 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from 9-4 1938 to 11-10 1947  
that I last saw him alive on 11-9 1947  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Josephine Dodson

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 13 - 1883  
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis <sup>Duration 10 yrs</sup>

8. AGE: Years 64 Months 7 Days 27 If less than one day hr. min.

9. Birthplace Salem Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Retired

MOTHER FATHER

12. Name W. D. Dodson

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

14. Maiden name Geruchia Castillo

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations CPD

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mye Josephine Dodson

(b) Address Lees Summit Mo

17. (a) Burial (burial, cremation or removal) (b) Date thereof 11-12-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Lees Summit, Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director N. B. Langford

(b) Address Lees Summit Mo

19. (a) NOV. 13 1947 (Date received local registrar)

(b) Ronald C. Barnham (Registrar's signature) RTD

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address Lees Summit Mo Date signed 11/10/47

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

**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. 3833

P. O. Address Lee's Summit

**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.**