

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13711

3804

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 4456 Lindell Blvd.			
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital				d. STREET ADDRESS (If rural, give location) 4456 Lindell Blvd.					
3. NAME OF DECEASED (Type or Print) Hugh Dodson			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH Apr. 27 1949			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Dec. 10- 1866		9. AGE (In years last birthday) 82		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		9. AGE (In years last birthday) 82		10. CITIZEN OF WHAT COUNTRY? _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Arkansas			12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Hugh Dodson			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Katherine Dodson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. _____			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Katherine Dodson, 4456 Lindell			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumonia (Hypostatic) DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 1 mo.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) 83rd		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. HOW DID INJURY OCCUR? 331 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331 X		22. I hereby certify that I attended the deceased from 4-11-1949 , to 4-27-1949 , that I last saw the deceased alive on 4-25-1949 , and that death occurred at 8:00 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) med. U			23b. ADDRESS 634 No Grand			23c. DATE SIGNED 4-28-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 29, 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. APR 28 1949		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 840 Lindell Blvd.			

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

W H Van Matre

Licensed Embalmer No. *2825*

P. O. Address. *4840 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.