

THE DIVISION OF HEALTH OF MISSOURI
 FILED NOV 14 1949 STANDARD CERTIFICATE OF DEATH

36022

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6128 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Emmence</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Emmence</u>	
c. LENGTH OF STAY (in this place) <u>30 yrs.</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) <u>Younger</u> c. (Last) <u>Dodson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-21 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Feb 12-1867</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
13a. FATHER'S NAME <u>Kelles Dodson</u>			13b. MOTHER'S MAIDEN NAME <u>Waucay Huff</u>		14. NAME OF SPOUSE OR WIFE <u>Maggie Dodson</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0-0</u>		17. INFORMANT'S SIGNATURE OR NAME <u>George Lekey Dodson</u> ADDRESS	
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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) <u>Apoplexy</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterial Hypertension</u> 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 <u>334X</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept 20, 1949, to Sept 21, 1949, that I last saw the deceased alive on Sept 20, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. Robert Younger Dodson</u> (Degree or title)		23b. ADDRESS <u>Summersville</u>		23c. DATE SIGNED <u>Oct 26</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 22-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Flat Wood</u>	
24d. LOCATION (City, town, or county) (State) <u>Near Emmence Mo.</u>		DATE REC'D BY LOCAL REG. <u>11-4-49</u>		REGISTRAR'S SIGNATURE <u>G. S. Rhee</u> 306	
25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS			

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

RECEIVED 11/7/49
District Health Officer No. 8

District File Number 1127-687

Date Filed 11/10/49

NOV 14 1949

Emmerson
2555 555 555

George Robert
Hoff, M.D.
Medical Director
857 B
Feb 12 1967
Dobson

Report
W W M
Richard Dobson

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.....

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.

Done

Sept 22-1949
That body