MISSOURI DEPARTMENT OF HEALTH
(PHYSICIAN, MEDICAL EXAMINER OR CORONER)

CERTIFICATE OF DEATH

FILED MAY 18 1988 DELAYED 235046

STATE FILE NUMBER 124 49-044054

REGISTRATION DISTRICT NO. 058 PRIMARY REGISTRATION DISTRICT NO. 4087 REGISTRAR'S NO. 9999

DO NOT WRITE ON THIS STUB

2
4
5A (Type of Units)
7B
7C
8
10
12
14A
15A
15B
15C & E
15D
21A
24A
25
26
26
26
26
26
26
26
26
27
29A-F
29G-ST
29G-CO
29G-CY

VS 300 Rev. 1/78

FILED ON THE BASIS OF AN AFFIDAVIT FROM MYRTLE CALLAHAN & A COPY OF THE OBITUARY & A PICTURE OF THE TOMB STONE PASSED AWAY MARCH 21, 1949

DECEDENT

1. DECEDENT—NAME: FIRST George MIDDLE Richmond LAST DAWSON
2. SEX: Male
3. DATE OF DEATH (Mo., Day, Yr.): 3-21-1949
4. RACE—(e.g., White, Black, American Indian, etc.) (Specify): White
5a. AGE—Last Birthday (Yrs.): 81
5b. UNDER 1 YEAR: MOS.
5c. UNDER 1 DAY: DAYS / HOURS / MINS.
6. DATE OF BIRTH (Mo., Day, Yr.): 11-13-1867
7a. COUNTY OF DEATH: CARTER
7b. CITY, TOWN OR LOCATION OF DEATH: NEAR Van Buren
7c. HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number): Home
8. STATE OF BIRTH (If not in U.S.A., name country): Missouri
9. CITIZEN OF WHAT COUNTRY: USA
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ YES ☒ NO
13. SOCIAL SECURITY NUMBER: None
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
14b. KIND OF BUSINESS OR INDUSTRY:
15a. RESIDENCE—STATE: Mo
15b. COUNTY: CARTER
15c. CITY, TOWN OR LOCATION AND ZIP CODE: RR Van Buren, Mo
15d. STREET AND NUMBER:
15e. INSIDE CITY LIMITS (Specify Yes or No):

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS.

PARENTS

16. FATHER—NAME: FIRST George MIDDLE Washington LAST Dawson
17. MOTHER—MAIDEN NAME: FIRST Malinda MIDDLE Jane LAST Snider Dawson

DISPOSITION

18a. INFORMANT—NAME (Type or Print): Myrtle Dawson Callahan
18b. MAILING ADDRESS: STREET OR R.F.D. NO. Rt. 1 Box 55 CITY OR TOWN Silex STATE Mo ZIP 63377
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) DATE: Burial
19b. CEMETERY OR CREMATORY—NAME: Poca Hollow Cem.
19c. LOCATION CITY OR TOWN STATE: West of Van Buren, Mo
20a. FUNERAL SERVICES LICENSEE Or Person Acting As Such (Signature) LICENSE NUMBER: PHL Leuckel Fun. Home
20b. NAME OF FACILITY: Leuckel Funeral
20c. ADDRESS OF FACILITY: Van Buren, Mo
21a. REGISTRAR (Signature): Garland K. Land
21b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.): May 26 1988

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)
22b. DATE SIGNED (Mo., Day, Yr.)
22c. HOUR OF DEATH M
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To be Completed by MEDICAL EXAMINER or CORONER Only

23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)
23b. DATE SIGNED (Mo., Day, Yr.)
23c. HOUR OF DEATH M
23d. PRONOUNCED DEAD (Mo., Day, Yr.) ON
23e. PRONOUNCED DEAD (Hour) AT M

24a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)
24b. MO. LICENSE NO.
25. IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

26. IMMEDIATE CAUSE [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).]

PART I
(a)
DUE TO, OR AS A CONSEQUENCE OF:
(b)
DUE TO, OR AS A CONSEQUENCE OF:
(c)

Interval between onset and death

PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)

27. AUTOPSY (Specify Yes or No)
28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No)

29a. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)
29b. DATE OF INJURY (Mo., Day, Yr.)
29c. HOUR OF INJURY M
29d. DESCRIBE HOW INJURY OCCURRED
29e. INJURY AT WORK (Specify Yes or No)
29f. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
29g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, COUNTY, STATE)
30. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS ☐ YES ☐ NO ☐ UNK

TYPE OR PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

MO 580-0695 (9-85)

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_____ Signed_____
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.