

FILED MAR 13 1950

STANDARD CERTIFICATE OF DEATH

State File No. 4358

BIRTH NO. _____ REG. DIST. NO. 86 PRIMARY REG. DIST. NO. 4149 Registrar's No. 5-1950

1. PLACE OF DEATH a. COUNTY Crawford		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Crawford	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cuba, (Town proper)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cuba	
c. LENGTH OF STAY (In this place) 47		d. STREET ADDRESS (If rural, give location) 5280	
d. FULL NAME OF HOSPITAL OR INSTITUTION at Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Rufus	b. (Middle) P	c. (Last) Dodge	4. DATE OF DEATH (Month) (Day) (Year) March 5 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/4/1861	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 6	IF UNDER 6 HRS. Days 1	IF UNDER 1 MIN. Hours 	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)	10b. KIND OF BUSINESS OR INDUSTRY Carpentry	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Thomas K. Dodge	13b. MOTHER'S MAIDEN NAME Agnes McConnell	14. NAME OF HUSBAND OR WIFE Ada Virginia
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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. None	17. INFORMANT'S SIGNATURE OR NAME Ada Virginia Dodge	ADDRESS Cuba, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 15 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		331X
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Insulinism due to C.D.A.		10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 25 1950 to Mar 5, 1950, that I last saw the deceased alive on Feb 18, 1950 and that death occurred at 10:45 p.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. Siders M.D.	23b. ADDRESS Cuba, Missouri	23c. DATE SIGNED 3-7-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/7/50	24c. NAME OF CEMETERY OR CREMATORY Kinders Cemetery	24d. LOCATION (City, town, or county) (State) Cuba, Missouri
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DATE REC'D BY LOCAL REG. 3/7/50	REGISTRAR'S SIGNATURE Paul A. Shanks	FUNERAL DIRECTOR'S SIGNATURE Paul A. Shanks	ADDRESS Cuba, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

3-9-50

District Health Officer No. 5,

District File Number 3-50-164

Date Filed 3-10-50

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 _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Paul J. Handley
Student Embalmer No. _____
Licensed Embalmer No. 3472
P. O. Address Cuba, Mo.

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.