

FILED OCT 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29983

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 844

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WILLARD RT. #1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2316 N. FORT</u>		d. STREET ADDRESS (If rural, give location) <u>WILLARD RT. #1 Twp.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILLARD</u>	b. (Middle) <u>W.</u>	c. (Last) <u>DOKE</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>SEPT. 24 1950</u>

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>29 DEC. 1883</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. 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) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES H. DOKE</u>	13b. MOTHER'S MAIDEN NAME <u>JOCKY HARRLSON</u>	14. NAME OF HUSBAND OR WIFE <u>RHODA DOKE</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>RHODA DOKE</u>	ADDRESS <u>WILLARD, RT. #1</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atherosclerotic Heart Disease</u>		<u>3 1/2 yrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis with Encephalomalacia Internal Capsule - 1/4 in.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Breast</u>			<u>6 mo.</u>

19a. DATE OF OPERATION <u>None</u>	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) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	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 March, 1950, to Sept. 24, 1950, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William J. Paul, M.D.</u>	23b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>	23c. DATE SIGNED <u>9/25/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>9/26/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>HICKORY GROVE CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>N.W. OF SPRINGFIELD MO.</u>
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DATE REC'D BY LOCAL REG. <u>9-26-50</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.D. Gwinkingner & Co.</u>	ADDRESS <u>Spfld. Mo.</u>
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Max Rhodes

Licensed Embalmer No. _____

4071

P. O. Address _____

Springfield

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.