

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38924
Registrar's No. 9759

318

1003

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 60 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	2119
d. FULL NAME OF HOSPITAL OR INSTITUTION 4464 St. Louis Ave		STREET ADDRESS (If rural, give location) 4464 St. Louis Ave	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Victor	c. (Last) Dozier	4. DATE OF DEATH (Month) (Day) (Year) NOV. 3 1951
-------------------------------------	------------------	--------------------	------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 22 1864	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
-------------	------------------------	--	--------------------------------	------------------------------------	------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optometrist	10b. KIND OF BUSINESS OR INDUSTRY Optometry	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.
---	---	---	-----------------------------------

13a. FATHER'S NAME James Dozier	13b. MOTHER'S MAIDEN NAME Jane Jones	14. NAME OF HUSBAND OR WIFE Dolly Dozier
---------------------------------	--------------------------------------	--

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 ADDRESS James H. Dozier 4500 St. Louis Ave.
---	------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio - Sclerosis	DUE TO (b) Senility		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4570
--	--	---------------------------------

22. I hereby certify that I attended the deceased from Oct 1, 1951, to Nov 3, 1951, that I last saw the deceased alive on Nov 3, 1951, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. E. G. Lane M.D.	23b. ADDRESS 3546 Grandview Blvd	23c. DATE SIGNED Nov 4
------------------------------------	----------------------------------	------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov 6, 1951	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) Normandy Mo.
---	-----------------------	---	--

DATE REC'D BY LOCAL REG. NOV 5 1951	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS King J. Marcell 4711 St. Louis Ave
-------------------------------------	-------------------------------------	---

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Walker

Licensed Embalmer No. 3575

P. O. Address Howe, 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.