

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13851**
Registrar's No. **364A**

21115
FILED APR 20 1953

REG. DIST. NO. **128**

PRIMARY REG. DIST. NO. **2000**

396
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dadeville		d. STREET ADDRESS (If rural, give location) 0290	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED a. (First) William b. (Middle) Eugene c. (Last) Dodson			4. DATE OF DEATH (Month) 4 (Day) 6 (Year) 53
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 4-6-53
9. AGE (In years last birthday) —		IF UNDER 1 YEAR —	IF UNDER 12 HRS. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Springfield, Mo.
12. CITIZEN OF WHAT COUNTRY? America		13a. FATHER'S NAME William Elwayne Dodson	
13b. MOTHER'S MAIDEN NAME Willa Mae Kirby		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Willa M. Dodson Dadeville Mo		ADDRESS	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Atelectasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		7620	
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?	
22. I hereby certify that I attended the deceased from April 6, 1953 , to April 6, 1953 , that I last saw the deceased alive on April 6, 1953 , and that death occurred at 8:20 m., from the causes and on the date stated above.			
23a. SIGNATURE J. Green (Degree or title) MD		23b. ADDRESS Springfield Mo	23c. DATE SIGNED 4-8-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-8-53	24c. NAME OF CEMETERY OR CREMATORY Masonic	24d. LOCATION (City, town, or county) (State) Dadeville Mo
DATE REC'D BY LOCAL REG. 4-15-53	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE W.R. Allison ADDRESS Greentield Mo	

INSTITUTION

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 W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield 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.