

FILED JUN 3 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17190
Registrar's No. 223

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>223</u>		
1. PLACE OF DEATH a. COUNTY <u>Butler</u> <u>0124</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u> c. LENGTH OF STAY (In this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Doctor's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> <u>1631</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Dexter</u> <u>1</u> d. STREET ADDRESS (If rural, give location) <u>215 N. E. Main</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Liora</u> b. (Middle) <u>Leanna Loti</u> c. (Last) <u>Dowdy</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 22, 1953</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u>		8. DATE OF BIRTH <u>Aug. 19, 1881</u>		
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u>		IF UNDER 1 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House-keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Stoddard County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>David Dodd</u>			13b. MOTHER'S MAIDEN NAME <u>Melvina Ezell</u>		14. NAME OF HUSBAND OR WIFE <u>Armstead Dowdy (Dec'd)</u>			
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>----</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Altha Wilson, Dexter, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute pulmonary edema</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Advancing age</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Incarcerated ventral hernia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>unknown</u> <u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?				
22. I hereby certify that I attended the deceased from <u>5-21, 1953</u> , to <u>5-22, 1953</u> , that I last saw the deceased alive on <u>5-22, 1953</u> , and that death occurred at <u>1:50 P.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Robert C. Engelhardt</u> (Degree or title)				23b. ADDRESS <u>Kaplan Building, Mo.</u>		23c. DATE SIGNED <u>5/27/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-24-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Armstead Dowdy</u>		24d. LOCATION (City, town, or county) (State) <u>R.F.D. #3, Dexter, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>5/29/53</u>		REGISTRAR'S SIGNATURE <u>R. A. Minette</u> <u>489</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Strickland-Rainey Dexter, Mo.</u>				

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

RECEIVED

JUN 2 1953
BUTLER CO. HEALTH CENTER

FILE No. _____

STATEMENT BY LICENSED EMBALMER

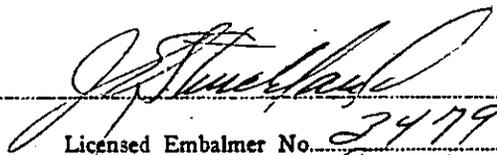
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 3479

P. O. Address West, 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.