

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1953
BIRTH NO. _____ REG. DIST. NO. **282** PRIMARY REG. DIST. NO. **5982** Registrar's No. **92**

0840

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

1. PLACE OF DEATH a. COUNTY POLK, (Mooney Township)		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY POLK	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Halfway, RFD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Halfway	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 12 miles SE of Halfway	
d. FULL NAME OF HOSPITAL OR INSTITUTION 12 Miles SE of Halfway			

3. NAME OF DECEASED (Type or Print) Mary	a. (First) Mary	b. (Middle) E.	c. (Last) Dodd	4. DATE OF DEATH (Month) (Day) (Year) July 2, 1953
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Oct. 29th, 1866	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 8 Days 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housework		11. BIRTHPLACE (City and State or Foreign Country) Polk County, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Allen Pendergraft	13b. MOTHER'S MAIDEN NAME Irene Self	14. NAME OF HUSBAND OR WIFE Mose G. Dodd
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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 Oscar Dodd, Halfway, Missouri	ADDRESS Halfway, Missouri
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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, asthenia, 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) Cerebral Thrombosis		Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) None		Unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

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., to 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 **May 22, 1949**, to **July 2, 1953**, that I last saw the deceased alive on **May 27, 1953**, and that death occurred at **6:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Hanna A. Agnew D.O.	23b. ADDRESS Pleasant Hope, Mo.	23c. DATE SIGNED July 3, 1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE July 4, 1953	24c. NAME OF CEMETERY OR CREMATORY Rock Prairie Cemetery	24d. LOCATION (City, town, or county) (State) Rock Prairie, Missouri
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DATE REC'D BY LOCAL REG. 7/25/53	REGISTRAR'S SIGNATURE Ralph Gordon	25. FUNERAL DIRECTOR'S SIGNATURE W. D. Ewin	ADDRESS Pleasant Hope, Mo.
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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

William B. Erwin

Licensed Embalmer No. *3092*

P. O. Address *Polk, 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.