

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27405

State File No.

FILED JUL 24 1953

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>333</u> | | PRIMARY REG. DIST. NO. <u>3074</u> | | Registrar's No. <u>112</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission): a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u> d. STREET ADDRESS (If rural, give location) <u>207 Cresap Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Samuel</u> b. (Middle) <u>Casper</u> c. (Last) <u>Dozier</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>7-11-1953</u> | | 5. SEX <u>Male</u> | | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>6-17-1882</u> | | 9. AGE (In years last birthday) <u>71</u> if UNDER 1 YEAR: Months _____ Days _____ if UNDER 1 Mth: Hours _____ Mins. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Charles Dozier</u> | | | 13b. MOTHER'S MAIDEN NAME <u>MARGARET ANN DARBY</u> | | 14. NAME OF HUSBAND, OR WIFE <u>Maud Dozier</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>494-01-7822</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Baile Dozier - Chicago Ill</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>Arteriosclerotic Cardiovascular disease - Hypertension</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Renal failure</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 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) <u>442X</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 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>7-7</u> , 19 <u>53</u> , to <u>7-11</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-10</u> , 19 <u>53</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Walter Sargent M.D.</u> | | | | 23b. ADDRESS <u>Sikeston Mo</u> | | 23c. DATE SIGNED <u>7-11-53</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>7-13-1953</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>BLODGETT</u> | | 24d. LOCATION (City, town, or county) (State) <u>BLODGETT MO</u> | |
| DATE REC'D BY LOCAL REG. <u>7-14-53</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Clara Hunter</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welsh Funeral Home - Sikeston Mo</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUL 20 1953

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 153-165

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sebaston 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.