

14240

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 17 1957

STATE FILE NUMBER

Registration District No. 282 Primary Registration District No. 5971 Registrar's No. 45

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Polk</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural-Marion</b>		c. CITY OR TOWN <b>Rural-Marion</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pleasant View Rest Home</b>		d. STREET ADDRESS (If outside, give location) <b>0840</b>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>Edgar</b> Last <b>Dozier</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 1889</b>
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Ice &amp; Coal Merchant</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	
13. FATHER'S NAME <b>L.B. Dozier</b>		14. MOTHER'S MAIDEN NAME <b>Emma Ray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs Irene Gardner, Lola Kansas</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>334 X</b>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>April 9-17</b> to <b>April 11-17</b> and last saw her alive on <b>4-9-57</b> Death occurred at <b>9:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. McCrean MD</b>		22b. ADDRESS <b>Balwan Mo</b>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REBURIAL (Specify) <b>Burial</b>	23b. DATE <b>April 13, 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Barren Creek</b>	23d. LOCATION (City, town, or county) (State) <b>Polk Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Pitts Funeral Home - Bolivar, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-10-1957</b>	26. REGISTRAR'S SIGNATURE <b>Ralph Harden per Quill</b>

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.....  
Signature of Student Embalmer

Signed *Richard J. Pitts*

Licensed Embalmer No. *493*

P. O. Address *Bolivar*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.