

FILED AUG 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH30613
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY <i>bernon</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Newton</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Nevada</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Joplin</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital #3</i>		Length of stay in 1b <i>6 years</i>		d. STREET ADDRESS (If outside, give location) <i>Rural Route 4</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>CLINTON</i> Middle <i>ALFRED</i> Last <i>DODSON</i>				4. DATE OF DEATH Month <i>August</i> Day <i>8</i> Year <i>1957</i>				
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>April 14, 1908</i>		9. AGE (In years last birthday) <i>49</i>	IF UNDER 1 YEAR Months <i>3</i> Days <i>24</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>ALTOONA, PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		
13a. FATHER'S NAME <i>Charles Dodson</i>		13b. MOTHER'S MAIDEN NAME <i>Gertrude J. Stutz</i>		14. NAME OF HUSBAND OR WIFE <i>Unknown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>491-12-0263</i>		17. INFORMANT Address <i>Hospital records</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Meningo-encephalitis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>years</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Sues</i>								
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 SUICIDE - HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>025X</i>						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> 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 <i>June 27, 1951</i> to <i>Aug 8/57</i> and last saw ^{her} him alive on <i>Aug 8/57</i> Death occurred at <i>9:55 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Paul L Barone MD</i>				22b. ADDRESS <i>State Hospital 3 Nevada</i>		22c. DATE SIGNED <i>Aug 8/57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>8-10-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Osborne - Cem</i>		23d. LOCATION (City, town, county) <i>Joplin</i> (State) <i>Mo</i>			
24. FUNERAL DIRECTOR <i>Johnson - Sime - Senior</i>		ADDRESS <i>Wald City</i>		25. DATE RECD. BY LOCAL REG. <i>8-21-1957</i>		26. REGISTRAR'S SIGNATURE <i>Ormal J. Ferry</i>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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 *Jack C. Simpson*
Licensed Embalmer No. *4647*
P. O. Address *Webb City,*

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.