

Health, Welfare
Public Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

322707
STATE FILE NUMBER

FILED SEP 30 1957

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Charleston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>316 W. Commercial</u>		Length of stay in 1b <u>16 Yrs</u>	d. STREET ADDRESS <u>316 W. Commercial</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Johnnie</u> Middle <u>Earl</u> Last <u>Dotson</u>			4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>	11. BIRTHPLACE (City and state or country) <u>Hickman, Ky.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Fleming Dotson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Benton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. I</u>		16. SOCIAL SECURITY NO. <u>407-09-8772</u>	17. INFORMANT Address <u>Mo. Mrs. Madeline Dotson, Charleston</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arterio-sclerotic heart disease A/K</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had Coronary Thrombosis Mar 1957 A 200</u>					INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u>
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.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____					
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 <u>9/8/57</u> to _____ and last saw ^{her} _{him} alive on <u>9/8/57</u> Death occurred at <u>5:40 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>E. Charles Ralving M.D.</u>			22b. ADDRESS <u>Charleston Mo</u>		22c. DATE SIGNED <u>9/15/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
24. FUNERAL DIRECTOR <u>The Nunnelee Funeral Chapel</u> Charleston, Mo.		25. DATE RECD. BY LOCAL REG. <u>9-20-57</u>	26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hathorn</u>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Miss. Co. Health Dep
County File No. _____
Date Filed 9-23-5

EX-1
1957

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 John F. Neumiller Jr
Licensed Embalmer No. 380

P. O. Address Charlotte

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.