

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

33416

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8176**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN East St. Louis 8/20	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 837 North 36th Street	
3. NAME OF DECEASED (Type or print) First LESTER Middle A. Last DODD		4. DATE OF DEATH Month Sept. Day 1 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 24, 1899 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unavailable	11. BIRTHPLACE (City and state of country) Iowa
13. FATHER'S NAME Joseph Dodd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Donald Rider, Newton, Iowa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Carcinoma of Nasopharynx with metastases		INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO (c) 146x	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour _____ 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 8/2/57 to 9/1/57 and last saw ^{her} him alive on 9/1/57 Death occurred at 7:25 P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Carl Smith M.D.		22b. ADDRESS BARNES HOSPITAL	
		22c. DATE SIGNED 9/2/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23c. NAME OF CEMETERY OR CREMATORY Local	
23b. DATE 9-3-57		23d. LOCATION (City, town, or county) (State) Baxter, Iowa.	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		26. REGISTAR'S SIGNATURE Carl Smith M.D.	
ADDRESS		25. DATE RECD. BY LOCAL REG. SEP 3 '57	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 J. Haines*
Licensed Embalmer No. *41*

P. O. Address *W. B. H.*

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.