

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47083
STATE FILE NUMBER

FILED JAN 7 1958

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 212

7. S. 300
ev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Verdon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Greenfield</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>State Hospital No. 3</u> Length of stay in 1b <u>2 yrs 6 mos 9 days</u>		d. STREET ADDRESS (If outside, give location) <u>312 Skouse Str.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>STEPHEN</u> Middle <u>EDGAR</u> Last <u>DODSON</u>			4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1957</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1873</u>	9. AGE (In years at birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail carrier</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas Dodson</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel Moore</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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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>Unknown</u>	17. INFORMANT. <u>Hospital records</u> Address
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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>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>
	DUE TO (c) <u>4200</u>
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.)
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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
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21. I attended the deceased from <u>12/31/56</u> to <u>12/24/57</u> and last saw her/him alive on <u>12/24/57</u> Death occurred at <u>2:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>George Esker, M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital No. 3</u>	22c. DATE SIGNED <u>12/24/57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-28-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>	23d. LOCATION (City, town, or county) (State) <u>Greenfield Mo</u>
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24. FUNERAL DIRECTOR <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-30-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna G. Ferris</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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VS APR 5 1960

FEB 17 1958

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 *W. R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greenville*

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.