

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017224

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 101

Primary Registration District No. 5405

Registrar's No. 32

300
-57

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| 1. PLACE OF DEATH a. COUNTY Douglas | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Douglas | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN "Ava" Jackson | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Ava |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) 0340 |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Lvy Myrtle Dobbs | | | 4. DATE OF DEATH Month Day Year Apr. 27, 1959 | | | |
|--|--|--|---|--|--|--|

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|----------------|---------------------------|--|------------------------------------|---------------------------------------|---|--------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 10, 1889 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
|----------------|---------------------------|--|------------------------------------|---------------------------------------|---|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (City and state or country) Dora, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME John Freeman (Mont) Tetrick | 13b. MOTHER'S MAIDEN NAME Rena E. Hicks | 14. NAME OF HUSBAND OR WIFE Ed Dobbs |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address Ed Dobbs, Route 5, Ava, Missouri |
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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) Died suddenly. no doctor attended her. | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) attended her. | |
| | 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"/> |

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| 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. |
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|---|--|--|
| 20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her/him alive on _____
Death occurred at 11:45 P. M. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Drap or title) Wesal Bushman L.R. | 22b. ADDRESS Ava Mo | 22c. DATE SIGNED May 23-59 |
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|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4-30-59 | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Home | 23d. LOCATION (City, town, or county) (State) Drury, Missouri |
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| 24. FUNERAL DIRECTOR Clinkingbeard Funeral Home, Ava, Mo. | 25. DATE RECD. BY LOCAL REG. May 23-59 | 26. REGISTRAR'S SIGNATURE Wesal Bushman |
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(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.

840

JAN 14 1980

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 G. Blenkinslee

Licensed Embalmer No. *4830*.....

P. O. Address *Avon, Mo.*.....

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.