

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024422

FILED VS AUG 4 1959

Registration District No. 35 Primary Registration District No. 304 Registrar's No. 57

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		Length of stay in lb <u>68 1/2 hrs</u>	c. CITY OR TOWN <u>Carrollton</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>Staton Clinic.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>215 South Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Denice</u> Middle <u>Gaye</u> Last <u>Dotson</u>	4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>Child</u>	8. DATE OF BIRTH <u>7-26-59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>68 1/2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Carrollton Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Gene Dotson</u>	13b. MOTHER'S MAIDEN NAME <u>Bonnie Wheeler</u>	14. NAME OF HUSBAND OR WIFE <u>Infant</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>None</u>	17. INFORMANT <u>Emma Winfrey (Carrollton Mo.)</u>
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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>Premature</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>26 Weeks</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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <u>10</u> 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 <u>Carrollton</u>	COUNTY <u>Carroll</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>July 24/59</u> to <u>July 29/59</u> and last saw her alive on <u>July 29/59</u> Death occurred at <u>7:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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21a. SIGNATURE <u>R. Hamilton Staton, M.D.</u> (Degree or title)	21b. ADDRESS <u>Carrollton, Mo</u>	21c. DATE SIGNED <u>July 29 1959</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE <u>7-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>Carrollton</u>
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24. FUNERAL DIRECTOR <u>Marshall F. Home (Carrollton Mo.)</u>	ADDRESS <u>Carrollton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-30-59</u>	26. REGISTRAR'S SIGNATURE <u>Dr. Herbert Calver</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Body was not embalmed. Placed in a casket., Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton

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