

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019215

FILED VS JUN 6 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 91

ENDED

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Ozark	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains, Missouri		Length of stay in 1b 9 days	c. CITY OR TOWN Gainesville Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION West Plains Memorial		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Bridges Twsp. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Gaudia Middle S. Last Dodson			4. DATE OF DEATH Month 5 Day 21 Year 1960		
5. SEX Fe.	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-25-1885	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Marshfield, Mo.		12. CITIZEN OF WHAT COUNTRY Us S. A.
13a. FATHER'S NAME Wesley Pitchford		13b. MOTHER'S MAIDEN NAME Sally Davis		14. NAME OF HUSBAND OR WIFE John Dodson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address John Dodson, Gainesville, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Circulatory Failure		8 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Statur Asthmaticus - Post-operative	4 days
	DUE TO (c) Cholecystectomy - Acute Gangrenous Cholecytitis	4 days
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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 5-12-60 to 5-21-60 and last saw her/him alive on 5-21-60
Death occurred at 10 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. B. Still M.D.</i>	22b. ADDRESS West Plains Mo	22c. DATE SIGNED 5/23/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-23-1960	23c. NAME OF CEMETERY OR CREMATORY Smith Chapel
23d. LOCATION (City, town, or county) Ozark County, Missouri		(State)

24. FUNERAL DIRECTOR Clinkingbeard, Gainesville, Mo.	25. DATE RECD. BY LOCAL REG. 5-31-60	26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Casey

Licensed Embalmer No. 4885

P. O. Address San Antonio

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.