

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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-60-030518  
4381 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

INDEXED

|   |   |   |  |  |  |  |                                  |
|---|---|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |  |                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Kansas City</u>   |   | Length of stay in lb<br><u>Life</u>   |  | c. CITY OR TOWN<br><u>Kansas City</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |                                  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br><u>Trinity Lutheran</u>  |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                | d. STREET ADDRESS<br><u>1711 Hardesty</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Clarence Dean Dodson</u>   |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>8-14-60</u>   |  |  |                                  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>WHT</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8-4-60</u>  | 9. AGE (last birthday)   | IF UNDER 1 YEAR<br>Months Days Hours                                       | IF UNDER 24 HR<br>Min. <u>59</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><u>retired</u>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><u>Kan. City - Mo.</u>   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                               |                                  |
| 13a. FATHER'S NAME<br><u>Daniel Raymond Dodson</u>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Hazel Juanita Milliner</u>                               |  | 14. NAME OF HUSBAND OR WIFE<br><u>none</u>   |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><u>no</u>  |   | 16. SOCIAL SECURITY NO.<br><u>none</u>  | 17. INFORMANT<br><u>Hazel Dodson</u>   |  | Address <u>Kan. City, Mo. 1711 Hardesty</u>  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>9 pneumonia</u>  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |   | DUE TO (b)  |  | 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                                  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <u>Birth</u> to <u>Birth + 1 hr</u> and last saw <u>her</u> alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |  |  |                                  |
| 22a. SIGNATURE (Degree or title)<br><u>Robert M. Myers M.D.</u>   |   |   | 22b. ADDRESS<br><u>1025 Duane Bldg</u>   |  |  | 22c. DATE SIGNED<br><u>8 Aug 60</u>  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><u>17 Aug 60</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Trinity Hospital</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>K-C, Mo.</u>   |  |  |                                  |
| 24. FUNERAL DIRECTOR<br><u>James, M.D. Trinity Hospital</u>   |   |   | ADDRESS  | 25. DATE RECD. BY LOCAL REG.<br><u>8-26-60</u>   | 26. REGISTRAR'S SIGNATURE<br><u>R. M. Myers</u>  |  |                                  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert M. Myers

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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