

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030049

STATE FILE NUMBER

AMENDED

Registration District No. 200 Primary Registration District No. _____ Registrar's No. 143

FILED AUG 31 1961

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>La Plata</u>		Length of stay in 1b <u>46 Yrs</u>	c. CITY OR TOWN <u>La Plata</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SABRA NICHOLS DODSON</u>			4. DATE OF DEATH Month Day Year <u>August 11, 1961</u>
5. SEX <u>F</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>5/11/67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>94</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u> IF UNDER 24 HR: Hours <u>---</u> Min. <u>---</u>
11. BIRTHPLACE (City and state or country) <u>Mendon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James W. Nichols</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hendrie</u>	14. NAME OF HUSBAND OR WIFE <u>George A. Dodson</u>
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 Address <u>Mrs. Elizabeth Carpenter, La Plata</u>
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>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</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			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs.</u>
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 <u>July 28, 1961</u> to <u>Aug 11, 1961</u> and last saw her alive on <u>Aug 11, 1961</u> Death occurred at <u>6:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold R. Vohr M.D.</u>		22b. ADDRESS <u>La Plata, Mo.</u>	22c. DATE SIGNED <u>8/11/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>Aug 13, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wilson Funeral Home, La Plata, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/16/61</u>	26. REGISTRAR'S SIGNATURE <u>Cuth McNeely</u>

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AUG 31 1961

SEP 7 1961

DEC 12 1962

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 Kenneth M. Wilson

Licensed Embalmer No. 4701

P. O. Address La Plata 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.