

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015182

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1925

FILED APR 20 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY JACKSON		b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		a. STATE Mo.		b. COUNTY JACKSON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hyde Park Nursing Home		Length of stay in lb 75 years		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 8312 Wabash		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8312 Wabash		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First PEARL		Middle Dodson		Last Dodson		Date 4 5 1962	
5. SEX FEMALE	6. COLOR OR RACE CACN.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1881	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Strasburg, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph McChiston			13b. MOTHER'S MAIDEN NAME UNKNOWN		13c. NAME OF HUSBAND OR WIFE Charles H. Dodson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Lillian Jenkins 4519 Wyoming			
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) Pulmonary edema						2 hrs	
DUE TO (b) Arteriosclerotic Ht Disease						2 hrs +	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia						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. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) March 18, 1962		20f. CITY, TOWN, OR LOCATION April 5 1962	
20g. COUNTY Mo.		20h. STATE Mo.		21. I attended the deceased from March 18, 1962 to April 5 1962 and last saw her alive on March 24 1962 Death occurred at 7:34 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]			22b. ADDRESS 730 Professional Bldg Kansas City, Mo.			22c. DATE SIGNED 4/6/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town, or county) (State) KANSAS CITY Mo.	
24. FUNERAL DIRECTOR Muehlebach		ADDRESS 6800 Troast		25. DATE RECD. BY LOCAL REG. 4-6-62		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

H. G. DODSON, J. I. MEDICAL CERTIFICATION

Trinity Lutheran Hosp.
31st & Wyandotte

Dr. Wm. H. Goodson, Jr.
Prof. Bldg
VI 2-3434

3:30 - 6:30

Call again to verify

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 W. H. Goodson, Jr.

Licensed Embalmer No. 4421

P. O. Address Kansas City, 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.