

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014742
STATE FILE NUMBER

Registration District No. 375 Primary Registration District No. 6279 Registrar's No. 8

FILED APR 2 1963

DO NOT WRITE ON THIS STUB
AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1 1140				
2 1140				
3				
4 0				
5 1				
6				
7 0				
8 0				
9 481X	ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	MEDICAL CERTIFICATION
10				
11				
12 90-2				
13 1-0				

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Gasconade Township</u>		c. CITY OR TOWN <u>Hartville</u>	
Length of stay in 1b <u>Lifetime</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Rt 2</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Eary</u> Last <u>Dodson</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>27</u> Year <u>63</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>72</u>
11a. FATHER'S NAME <u>Frank Dodson</u>		11b. MOTHER'S MAIDEN NAME <u>Nettie Peters</u>	11. BIRTHPLACE (City and state or country) <u>Wright County, Mo.</u>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>Opal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Opal Dodson Hartville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arthritis</u>			<u>Years</u>
DUE TO (c) <u>Influenza</u>			<u>Weeks</u>
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
19. WAS AUTOPSY PERFORMED? YES <input 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 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>1940</u> to <u>Mar. 27, 63</u> and last saw her/him alive on <u>Mar. 26 1963</u>		Death occurred at <u>5:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>J. E. Worthy, D.O.</u>		22b. ADDRESS <u>Hartville Mo.</u>	22c. DATE SIGNED <u>3-29-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-29-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newton School Cemetery</u>	23d. LOCATION (City, town, or county) <u>Wright County, Mo.</u>
24. FUNERAL DIRECTOR <u>Max L Miller Mansfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-1-1963</u>	26. REGISTRAR'S SIGNATURE <u>Bonnie J. Jones</u>

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 Max L. Miller

Licensed Embalmer No. 4720

P. O. Address Manassas, 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.