

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0001347

STATE FILE NUMBER

**DO NOT WRITE ON THIS STUB**

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 15

FILED JAN 18 1967

VS 300  
Rev. 4/59

10425

20420

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clinton</b>		c. CITY OR TOWN <b>Brownington</b>	
Length of stay in 1b <b>2Wk,s</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Clinton General</b>		d. STREET ADDRESS (If outside, give location) <b>R R # 2</b>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Cary Dodson</b>			4. DATE OF DEATH Month Day Year <b>January 10 1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-1884</b>
9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Henry Co Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>Thomas M Dodson</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Delozier</b>		14. NAME OF HUSBAND OR WIFE <b>Eva Dodson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-18-5261</b>	
17. INFORMANT <b>Mrs George Nichols</b>		Address <b>Brownington Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
DUE TO (b) <b>Arterio sclerosis heart disease</b>			<b>6 mo.</b>
DUE TO (c) <b>Generalized arterio sclerosis</b>			<b>sev. yrs.</b>
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 <b>12-23-66</b> to <b>1-10-67</b> and last saw him alive on <b>1-9-67</b> Death occurred at <b>1:15 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>James O. Smith M.D.</i>		22b. ADDRESS <b>Clinton, Mo.</b>	22c. DATE SIGNED <b>1-10-67</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Brownington Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Sickman &amp; Dunning Clinton Mo</b>		25. DATE RECD. BY LOCAL REG. <b>JAN. 11, 1967</b>	26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>

JAN 26 1967

100-1-10-10

Permit obtained 1-11-67 (MB)

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 R. L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.