MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17541

JUL 25 1929

1. PLACE OF DEATH
County Cass
Township Peculiar
City ..... (No. ..... St. ..... Ward)

Registration District No. 156
Primary Registration District No. 5220

File No. .....
Registered No. 24

2. FULL NAME Carl Allen Dobson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28-1926

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	2	10	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cass Co. Mo.

PARENTS
10. NAME OF FATHER Charles F. Dobson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cass Co. Mo.
12. MAIDEN NAME OF MOTHER Nellie Shackelford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cass Co. Mo.

14. INFORMANT Chas F. Dobson
(Address) Harrisonville Mo.

15. FILED 5/8, 1929 D S Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1929

17. I HEREBY CERTIFY, That I attended deceased from 5/6, 1929 to 5/7, 1929 that I last saw him alive on 5/7, 1929, and that death occurred, on the date stated above, at 1:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Laryngeal Diphtheria

10

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) 10

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) David S Long, M. D.

5/8, 1929 (Address) Hville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Wills Cemetery	5/8 1929
20. UNDERTAKER	ADDRESS
Runnenburger Bros Co	Harrisonville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD