

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

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.

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

31776
 Do not use this space.

1. PLACE OF DEATH

(a) County Berry Registration District No. 29

(b) Township Crane Creek Primary Registration District No. 5046 Registered No. 29

(c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susan Elizabeth Dodson

(a) Residence, No. Crane Mo. Route No 1 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF P L Dodson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>82</u>	<u>2</u>	<u>13</u>		

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stone County Missouri

FATHER

13. NAME E Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kv.

MOTHER

15. MAIDEN NAME Nancy Neale

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kv.

17. INFORMANT (ADDRESS) Mrs Albert Johnson Crane Route No 1 No.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mars Hill DATE Apr. 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ret. Sping Aurora Mo.

20. FILED 9-8 1939 Edward Newman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw her alive on April 10, 1939. Death is said to have occurred on the date stated above, at 4 a.m.

The principal cause of death and related causes of importance were as follows:
Infermitie of Age -

Date of onset 1672

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. P. Sping, M. D.
 (Address) Crane, Mo.

RECEIVED

District Health Officer No. 6,

District 1039-2115

Date Filed OCT 18 1939

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. J. King*
Licensed Embalmer No. 2020
P. O. Address *Wesport 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 this body is not embalmed, above space should be left blank.