

Registration District No. 716

Primary Registration District No. 5945

Registrar's No. 5

DATE MAR 11 1940

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town CROCKER
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 years, months or days (Specify whether)

8. (a) PRINT FULL NAME J. A. Dodd
8. (b) If veteran, name war ✓
8. (c) Social Security No. 300

4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife JANE DODD
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased X July 25 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 6 If less than one day hr. _____ min. _____

9. Birthplace PULASKI-Co. (City, town, or county) (State or foreign country) 0

10. Usual occupation Retired FARMER

11. Industry or business
12. Name X Melton C. Dodd
13. Birthplace X Tenn. (City, town, or county) (State or foreign country)
14. Maiden name Eliza Norton
15. Birthplace X Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature X John M. Dodd
(b) Address Waverlyville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Crocker Mo.

18. (a) Signature of funeral director J. H. Hoops
(b) Address Crocker Mo.

19. (a) 3/13/40 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski
(c) City or town Crocker Mo (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1940 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from January 27 1940 to Feb 2 1940
that I last saw him alive on Feb 2 1940 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Due to arteriosclerosis

Due to stroke
Other conditions unknown
(Include pregnancy within 3 months of death)

Major findings: No operation
Of operations _____
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

23. Signature [Signature] (Specify type of place) (e) Means of injury ✓
Address Crocker Mo (M. D. or other) [Signature]
Date signed 3/13/40

Duration 7 Days
PHYSICIAN _____
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.

RECEIVED

District Health Officer No. 5,

District File Number 340 274

Date Filed 3840

Signed Paul B. Hooper

Licensed Embalmer No. 3261

P. O. Address Crocker, 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.

Registration District No. 716

Primary Registration District No. 3945

Registrar's No. 5

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Polk
 (b) City or town Jayvern
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Geoff Andrew Dodds
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 6 If less than one day _____ hr _____ min

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb 3/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place) _____ Means of injury _____

23. Signature W. J. Self (M. D. or other) _____

Address Excelsior Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

MAY 17 1940