DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25626

Registration District No. 496 — Primary Registration District No. 3025 — Registrar's No. 60

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 627 Snow (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community 37 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Linn

(c) City or town: Brookfield (If outside city or town limits, write "RURAL")

(d) Street No.: 627 Snow Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Mary Ann Dodson 325

3. (b) If veteran, name war ____

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: William Dodson

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: October 23, 1858 (Month) (Day) (Year)

8. AGE: Years 81 | Months 8 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace: Sullivan County, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: 1

FATHER
12. Name: Isaac Adams
13. Birthplace: Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Jane Head
15. Birthplace: Missouri. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: [signature]
(b) Address: Brookfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-2-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Rose Hill Cemetery.

18. (a) Signature of funeral director: Rusk Funeral Home
(b) Address: Brookfield, Mo.

19. (a) July 1st (Date received local registrar) (b) J. Thurs. M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 30 day ____ year 1940 hour 8 minute 20 a. M.

21. I hereby certify that I attended the deceased from Feb 17, 1940 to June 29, 1940, that I last saw her alive on June 29, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage — Apoplexy.	2 mo.
Due to: Arteriosclerosis — General.	9
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically

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)
While at work? ____ (e) Means of injury ____

23. Signature: Roy R Haley (M. D. or other) M.D.
Address: Brookfield Date signed 7/1/40

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 11,
District File Number 640-1248
Date Filed AUG 6 1941

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 H. Budwright

Licensed Embalmer No. 3718

P. O. Address Brookfield.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.