

FILED MAY 5 1944

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 72

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Excelsior Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 7 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Boone
(c) City or town Columbia Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mi. So West of Columbia
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Lawrence Dodd

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex male 5. Color or race W
6. (b) Name of husband or wife Mattie Walkins 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 27 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 6 27 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas J. Dodd
13. Birthplace S. Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hickam
15. Birthplace Boone Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Parkers Funeral Service
(b) Address Columbia, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-25-44
(Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo.

18. (a) Signature of funeral director Clarence Dehan

(b) Address Excelsior Springs Mo.

19. (a) 4-23-44 (Date received local registrar) Mrs. Madeline Redman (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 24
year 1944 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from 4-18-24
_____, 19____, to 4-24- 1944
that I last saw him alive on 4-24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 6 hrs.

Due to hypertension + arteriosclerosis
Due to _____

Other conditions (Include pregnancy within 3 months of death) 83a

Major findings: Of operations 0 Of autopsy 0
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) 0
(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?

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature Dr. M. P. Craven (M. D. or other) M.D.
Address Excelsior Springs Mo Date signed 4/25/44

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-4-47

AUG 3 1947

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

Carl Rapp

Licensed Embalmer No. 03458

P. O. Address Ex. Stgo. 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, fact should be so stated above.