S. No. 2
M—2-43
y. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1952

State File No.

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 2

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(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 (Specify whether years, months or days): —; In this community: 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 2 miles S of Harrisonville
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: Mary Barbara Dodd Sliffe
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: widow
6. (b) Name of husband or wife: Charles M Sliffe
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: July 24 1862 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
82	—	8	hr. — min.

9. Birthplace: Athens (City, town, or county) Ohio (State or foreign country)
10. Usual occupation: Home Maker
11. Industry or business:
FATHER
12. Name: James Hannan Dodd
13. Birthplace: Pittsburg (City, town, or county) Penna (State or foreign country)
MOTHER
14. Maiden name: Katherine Cabral
15. Birthplace: Athens (City, town, or county) Ohio (State or foreign country)
16. (a) Informant: Melissa Sliffe
(b) Address: 315 Somerville, Raton, New Mexico
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: Jan 4 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Orient Cemetery
18. (a) Signature of funeral director: KUNNENBURGER'S
(b) Address: HARRISONVILLE, MO.
19. (a) Jan. 4, 1945 (Date received by local registrar) (b) Margaret Valle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 2 day 1945 year 1945 hour 9 minute P M.
21. I hereby certify that I attended the deceased from Sept 1944, 19 Jan 2 1945, 19 that I last saw him alive on Jan 2 1945, 19 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Cardiac Insufficiency +	
Due to Goitre	4 wks.
Due to Cancer of Stomach	6 mon.
Due to with Gastric Hemorrhage	4 days.
Other conditions (Include pregnancy within 3 months of death): None.	

Major findings: Of operations: None.
Of autopsy: No

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): No.
(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: Dr E A Owen (M. D. or other) DO
Address: Harrisonville Mo Date signed 1/2 45

NR Corrected 1947 (Licensed Embalmer's Statement on Reverse Side)

APR 28 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 Ernest Rannenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.