

S. No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FITCH
State File No. **30910**
Registrar's No. **819**

FILED OCT 6 1947
Registration District No. **28**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:
2309 N. Grant
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Pete Dollison

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Dollison

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Feb. 7 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 8 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Farmer

MOTHER FATHER

12. Name J.G. Dollison

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

14. Maiden name Florence Hines

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

16. (a) Informant Russell Toothman

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 9/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-19-47 (b) M.E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 2309 N. Grant
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16 year 1947 hour 3 minute 20p. M.

21. I hereby certify that I attended the deceased from 1945 to Sept 16 1947 that I last saw him alive on Sept 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 12 hrs.

Due to Coronary - Ruptured Vein

Due to Brain

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 9/18/47

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:

(c) 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? Yes

While at work? Yes (Specify type of place) (c) Means of injury

23. Signature Max Fitch (M. D. or other) MO.

Address open hospital Date signed 9-18-47

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..... *Roy H. Mercer, Jr.*.....
Licensed Embalmer No..... *4432*.....
P. O. Address..... *Springfield, 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.