

FILED AUG 17 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

HAROLD LURIE  
State File No. 28289  
753  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. _____										
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>												
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>MOST OF LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		<u>0396</u>										
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>804 WEST OLIVE</u>				d. STREET ADDRESS (If rural, give location) <u>804 WEST OLIVE</u>												
3. NAME OF DECEASED (Type or Print) a. (First) <u>SADIE</u>		b. (Middle) <u>L.</u>		c. (Last) <u>DODSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG, 10, 1953</u>										
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAR, 2, 1870</u>		9. AGE (In years last birthday) <u>83</u>	<table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> </tr> <tr> <td></td> <td></td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR	Months	Days	Hours			Min.
IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR														
Months	Days	Hours														
		Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>										
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS FRED GILLICK SPRINGFIELD, MO</u>												
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				<p style="text-align: center;"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u></p> <p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>				INTERVAL BETWEEN ONSET AND DEATH <u>2 - year</u>								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)												
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?												
22. I hereby certify that I attended the deceased from <u>10-11-1952</u> to <u>8-10-1953</u> , that I last saw the deceased alive on <u>8-10-1953</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.																
23a. SIGNATURE (Degree or title) <u>Harold A. Lurie, M.D.</u>				23b. ADDRESS <u>Medical Arts Bldg. Springfield, Mo.</u>		23c. DATE SIGNED <u>8-11-53</u>										
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8/13/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN</u>		24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MISSOURI</u>										
DATE REC'D BY LOCAL REG. <u>8-11-53</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HERMAN LOHMEYER</u>		ADDRESS <u>SPRINGFIELD, MO</u>										

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Gene Schmeyer*

Licensed Embalmer No. *4784*

P. O. Address *Spfld, 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.