

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36520**
Registrar's No. **352**

FILED OCT 19 1953

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043**

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY MARION	
b. CITY OR TOWN HANNIBAL c. LENGTH OF STAY (in this place) 30 50 ³⁰		c. CITY OR TOWN HANNIBAL 0649	
d. FULL NAME OF HOSPITAL OR INSTITUTION LEVERING HOSPITAL		d. STREET ADDRESS (If rural, give location) MARK TWAIN REST HOME	

3. NAME OF DECEASED (Type or Print) ARTHUR B. DODD	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH 10-11-53	(Month)	(Day)	(Year)
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JUNE 1, 1874	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MRS. Hours	IF UNDER 1 MRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) CARROLTON, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME JAMES H. DODD	13b. MOTHER'S MAIDEN NAME JANE E. MARTIN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME CLARENCE J. DODD - HANNIBAL, MO.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Bladder		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Operated at Cancer Hospital Columbia			

19a. DATE OF OPERATION 2	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **Oct-9, 1953**, to **Oct-11, 1953**, that I last saw the deceased alive on **Oct-10, 1953**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. M. Lucke, M.D.	(Degree or title) 0	23b. ADDRESS Hannibal, Mo	23c. DATE SIGNED 10-12-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10-13-53	24c. NAME OF CEMETERY OR CREMATORY ANTIOCH CEMETERY	24d. LOCATION (City, town, or county) (State) ROLLS COUNTY, MO.
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DATE REC'D BY LOCAL REG. 10/12/53	REGISTRAR'S SIGNATURE E. M. Lucke, Deputy	25. FUNERAL DIRECTOR'S SIGNATURE Jack Schwartz	ADDRESS Hannibal, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED OCT 17 1953
MARION CO. HEALTH DEPT.
DATE FILED OCT 17 1953

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 _____

Jack Schwartz
Licensed Embalmer No. 4800

P. O. Address Hannibal, 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.