

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **4027**

FILED MAR 15 1954

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **251**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 71 yrs.		d. STREET ADDRESS (If rural, give location) 713 Albemarle St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 713 Albemarle St.			
3. NAME OF DECEASED (Type or Print) Amelia		4. DATE OF DEATH (Month) (Day) (Year) Mar. 8 1954	
a. (First)		b. (Middle)	
c. (Last) Dodd			
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 27 1883
9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME (Not known) Ward	13b. MOTHER'S MAIDEN NAME (Not known)	14. NAME OF HUSBAND OR WIFE Wm. O. Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME - ADDRESS Wm. O. Todd - 713 Albemarle - St. Joe	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) arterio sclerosis		not sure	
DUE TO (c) chronic myocarditis		not sure	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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) (Minute)	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 Dec 20, 1953 , to March 8, 1954 , that I last saw the deceased alive on March 7, 1954 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edna Roundy M.D.		23b. ADDRESS Kirkpatrick Bldg. St. Joe, Mo.	23c. DATE SIGNED March 9-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 11-1954	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
DATE REC'D BY LOCAL REG. Mar 10, 1954	REGISTRAR'S SIGNATURE Bother M. Allison	485 -	25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Alexander ADDRESS St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed _____

Wm. H. Alexander

Signed _____

Student Embalmer

Licensed Embalmer No. *4450*

P. O. Address *St. Joseph, 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.