

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7872

FILED APR 8 - 1957

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>197</u>	
1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>			
b. CITY OR TOWN <u>CAPE GIRARDEAU</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY OR TOWN <u>ORAN</u>		d. STREET ADDRESS (If rural, give location) <u>1000</u> <u>ORAN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CAPE OSTEOPATHIC HOSPITAL</u>				3. NAME OF DECEASED a. (First) <u>JIM</u> b. (Middle) _____ c. (Last) <u>DOTSON</u>			
4. DATE OF DEATH <u>MARCH 29 1957</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	
8. DATE OF BIRTH <u>FEB. 11 1884</u>		9. AGE (in years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>ABE DOTSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN TONER</u>		14. NAME OF HUSBAND OR WIFE _____			
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>?</u>		17. INFORMANT'S SIGNATURE OR NAME <u>JIM CRAWFORD</u> ADDRESS <u>ST. LOUIS 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Pulmonary Edema</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ch. Heart Failure</u> DUE TO (c) <u>Bronchial Asthma</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardio-vascular Renal Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1 yr.</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>241X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		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>3-26</u> , 1957, to <u>3-29</u> , 1957, that I last saw the deceased alive on <u>3-29</u> , 1957, and that death occurred at <u>12:55a.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. H. Schmeys, D.O.</u>				23b. ADDRESS <u>Chaffee, Missouri</u>		23c. DATE SIGNED <u>4/3/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MARCH 30 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FRIEND</u>		24d. LOCATION (City, town, or county) (State) <u>ORAN MO.</u>	
DATE REC'D BY LOCAL REG. <u>4-3-57</u>		REGISTRAR'S SIGNATURE <u>C. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith</u> ADDRESS <u>ORAN MO.</u>			

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

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