

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013933

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 19

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|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Lafayette</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Odessa</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Odessa</b> <sup>0548</sup><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |  | Length of stay in lb<br><b>1 Yr.</b>  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Theodore T. Dahlor</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 27, 1959</b>  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 17, 1878</b>  |
| 9. AGE (In years)<br><b>80</b>  |  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; none if retired)<br><b>Retired Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Jackson Co., Mo.</b>  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13a. FATHER'S NAME<br><b>August Dahlor</b>  | 13b. MOTHER'S MAIDEN NAME<br><b>Augusta McCuskey</b>   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Laura E. Dahlor</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                   | 16. SOCIAL SECURITY NO.<br><b>489-44-1588</b>  |
| 17. INFORMANT<br>Address<br><b>Wayland Dahlor, Odessa, Mo.</b>  |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. }<br>DUE TO (b) <b>arteriosclerotic heart disease</b><br>DUE TO (c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4200</b> |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE   |
| 21. I attended the deceased from <b>3-18-59</b> to <b>4-27-59</b> and last saw him alive on <b>4-26-59</b><br>Death occurred at <b>2:45 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Cecil L. Watson, M.D.</b>  |  | 22b. ADDRESS<br><b>Odessa Mo.</b>   | 22c. DATE SIGNED<br><b>4-28-59</b>   |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Apr. 29, 1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Odessa Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Odessa, Mo.</b>  |
| 24. FUNERAL DIRECTOR<br><b>Husman-Sparks</b>  | ADDRESS<br><b>Odessa, Mo.</b>  | 25. DATE RECD. BY LOCAL REG.<br><b>4-28-1959</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Emma Davidson</b>  |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed *William T. Sparks*

Licensed Embalmer No. *4431*  
P. O. Address *Odessa,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.