

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016628

STATE FILE NUMBER

FILED MAY 19 1959

Registration District No. 4

Primary Registration District No.

Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <b>ATCHISON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOLT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FAIRFAX</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bigelow</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Community Hosp.</b>		Length of stay in lb <b>4 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>7 mi S.W.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>HOWARD ROBERT DODSON</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 18, 1897</b>
9. AGE (In years of last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>Holt County, Mo</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>JOHN T. Dodson</b>	13b. MOTHER'S MAIDEN NAME <b>EFFIE HINKLE</b>
14. NAME OF HUSBAND OR WIFE <b>DERINDA MAY Dodson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>496-42-3422</b>
17. INFORMANT <b>MRS. HOWARD Dodson</b>		Address <b>Bigelow, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of Stomach</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 WKS -</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 Hour _____ Month, Day, Year _____ 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>July 1, 1957</b> to <b>MAY 11, 1959</b> and last saw <sup>him</sup> alive on <b>MAY 11, 1959</b> Death occurred at <b>9:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. F. Sweeney M.D.</b>		(Degree or title)	22b. ADDRESS <b>Oregon, Mo</b>
22c. DATE SIGNED <b>5/12/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAY 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT Hope Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Mound City, Mo.</b>
24. FUNERAL DIRECTOR <b>James H. Crawford</b>		ADDRESS <b>Mound City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 15, 1959</b>
26. REGISTRAR'S SIGNATURE <b>Marvin J. Schaller</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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MAY 21 1959

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 *James H. Beazley* .....

Licensed Embalmer No. *4796* .....

P. O. Address *Mound City* .....

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.