

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000934

FILED VS JAN 23 1961

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 30A

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>9 DAYS</b>		c. CITY OR TOWN <b>NIANGUA MO R2</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>BURGE Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>SMI SE</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>SUSIE</b> Middle <b>C</b> Last <b>DODSON</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>8</b> Year <b>1961</b>					
5. SEX <b>FEMALE</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>8-4-1880</b>		9. AGE (last birthday) <b>80</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13a. FATHER'S NAME <b>MARTIN BARNER</b>			13b. MOTHER'S MAIDEN NAME <b>LOUISE MILLER</b>			14. NAME OF HUSBAND - <del>GRANNE</del> <b>WILLIAM</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.		17. INFORMANT <b>WILLIAM DODSON NIANGUA MO R2</b>			Address	
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>Arteriosclerotic Heart Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</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) <b>Fracture, Timphe Pelvis</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown			
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 a.m. p.m.		Month, Day, Year							
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>1 Jan 1961</b> to <b>8 Jan 1961</b> and last saw her alive on <b>8 Jan 1961</b> Death occurred at <b>11 am</b> m of the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>GDC Callaway MD</b> (Degree or title)						22b. ADDRESS <b>Springfield, MO</b>		22c. DATE SIGNED <b>10 Jan 61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>1-8-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>COPENING</b>		23d. LOCATION (City, town, or county) (State) <b>WEBSTER CO MO</b>			
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-17-61</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Dwyer</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

SEP 26 1961

**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 George Stapp

Licensed Embalmer No. 3161  
P. O. Address W. L. Lane, MD

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.