JUL 4 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

20278

1. PLACE OF DEATH
County: Phelps
Township: Arlington
City: Newburg (No. ..... St. ..... Ward)

Registration District No. 676
Primary Registration District No. 5899

File No.
Registered No. 14

2. FULL NAME: Alexander Hodge

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. ~~If Married, Widowed, or Divorced~~.
HUSBAND OF (OR) ~~WIFE OF~~ Lucinda Hodge

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 27 1860

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Wright Co Mo.

PARENTS
10. NAME OF FATHER: Do not Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Do not Know
12. MAIDEN NAME OF MOTHER: Do not Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Do not Know

14. INFORMANT: Lucinda Hodge
(Address)

15. FILED 6/23, 1930 B T Lynch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 22 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to ....., 19..., that I last saw him alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Prostatitis
Pyl
9 Months (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Myocarditis
(duration) 6 mo 1 yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W B Smith, M. D.
6/23, 1930 (Address) Rolla. Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Roach Cemetery	6/23 1930
20. UNDERTAKER	**ADDRESS**
Lee Johnson	Newburg Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.