

JAN 1 1936

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

Do not use this space.

40182

1. PLACE OF DEATH

County Linn Registration District No. 500 File No. \_\_\_\_\_  
Township Jefferson Primary Registration District No. 5663 Registered No. 17  
City Waverly St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Martin Vanhuren Hodson  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mildred A. Hodson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
81 6 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farming

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Co. Missouri

13. NAME John Hodson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Missouri

15. MAIDEN NAME Agusta C. Daniel

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Mo.

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE Ladelle, Mo. DATE Dec. 29 1935

19. UNDERTAKER (ADDRESS) W. J. Shone Ladelle, Mo.

20. FILED Dec 29 1935 Geo O'Plowman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 22 1935 to Dec 27 1935

I last saw him alive on Dec 27 1935 Death is said

to have occurred on the date stated above, at 9:50 P.M.

The principal cause of death and related causes of importance were as follows:

Coronary embolism Date of onset \_\_\_\_\_

Other contributory causes of importance: Continuation over liver area from 141 a fall.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_  
(Signed) W. M. F. LaMare, M.D.  
(Address) Ladelle, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.  
Do not use this form.

**1. PLACE OF DEATH**

County Lynn Registration District No. 500 File No. \_\_\_\_\_  
 Township Jefferson Primary Registration District No. 5-665- Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martin Amburien Rodem  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>81</u>	MONTHS <u>6</u>	DAYS <u>13</u>	IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED Dec 28-1935 Geo. O. Plowman Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:  
Contusion over liver from a fall

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? accident Date of injury Dec 20, 1935

Where did injury occur? bedside, no  
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.  
at home  
 Manner of injury slipped on pavement  
 Nature of injury contusion

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_  
 (Signed) Wm J. L. Mancy, M.D.  
 (Address) Laclede mo

SUPPLEMENTARY

8-40182