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.

REC'D NOV 21 1938

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

34789
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kay
(c) City Kansas City
Registration District No. 399
Primary Registration District No. 1022
Registered No. 4125
(d) Street No. Wesley Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 320 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Irene A. Hodge
(a) Residence, No. 3918 Merrington St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Colin W. Hodge
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec-8-1907
7. AGE: Years 30 Months 9 Days 14 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.: Home
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): Brookfield Mo

FATHER
13. NAME: Albert T. Harris
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

MOTHER
15. MAIDEN NAME: Flora D. Myers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

17. INFORMANT (ADDRESS): Colin W. Hodge 3918 Merrington

18. BURIAL, CREMATION, OR REMOVAL
PLACE Utica Mo DATE Oct 24 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Eglar Funeral Home

20. FILED 10-23 1938 M. M. Crowe Ass't. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/22/ 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1938, to Oct 22, 1938
I last saw her alive on Oct 22, 1938. Death is said to have occurred on the date stated above, at 10 30 pm.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal obstruction	10/5/38
Peritonitis	10/11/38
Volvulus	
122 B1	

Other contributory causes of importance:

Name of operation Relieve obstruction Date of 10/8/38
What test confirmed diagnosis? Physical 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) R. W. Stapp, M. D.
(Address) 1103 Grand Ave.

Licensed Embalmer's Statement on Reverse Side)

Office Vi 3002
Dr R. P. Stapp
Professional Bldg
425 West Hyde Blvd
Res 9a6666

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.