

No. 2
-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26910

State File No. _____

791

1003

6806

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Enroute City Hospital #1 **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 25 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County _____
(c) City or town St. Louis **17**
(If outside city or town limits, write "RURAL")
(d) Street No. 3010 Park Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Rose Luville Hodges **322**

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: about 83
Years Months Days If less than one day
_____ hr. _____ min.

9. Birthplace Indiana **1**
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name ? Dewesse

13. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)

16. (a) Informant Bessie Hodges
(b) Address 920 N. Taylor

17. (a) Burial (b) Date thereof 8/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia, Mo.

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave.

19. (a) 1-1-1940 (b) J. Bredeck
Date received local registrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10
year 1940 hour 1:20 minute 15 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations gla
Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury 5

23. Signature Alfred Perry (M. D. or other) **5**
Address Chicago, Ill. Date signed 8/14/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

REC-1-1-1940

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.....

L.R. Casper

Licensed Embalmer No.....

2633

P. O. Address.....

2317 Lafayette

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 this body is not embalmed, fact should be so stated above.