

NOV 21 1940

Registration District No. 749

Primary Registration District No. 4450

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds  
(b) City or town Lesterville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds  
(c) City or town Lesterville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Lydia Catherine Hodges

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Charles H. Hodges 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 12 1943  
(Month) (Day) (Year)

8. AGE: Years 97 Months 4 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Black Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business 1

12. Name George Gallaher

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Serene Minor

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant John Hodges  
(b) Address Lesterville Mo.

17. (a) burial (b) Date thereof Sept. 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleview Mo.

18. (a) Signature of funeral director Norman White & Sons  
(b) Address Ironton Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1  
year 1940 hour 6 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Aug 1  
1940, to Sept 7 1940  
that I last saw her alive on Aug 31 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Isolated

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions mitral insufficiency  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature C. W. Fitzpatrick (M. D. or other) MD  
Address Lesterville, Mo Date signed Oct 14, 1940

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number. 10401077

Date Filed \_\_\_\_\_

**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. 3012

P. O. Address. Clinton, Mo.

**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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 86196

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 749

Primary Registration District No. 4450

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Reynolds  
(b) City or town Leasterville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Lydia Catherine Hodges

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
97 4 19 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9/18/1940 (b) E. M. Fitzpatrick  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 1  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature E. W. Fitzpatrick (M. D. or other) \_\_\_\_\_

Address Leasterville Mo signed \_\_\_\_\_

SUPPLEMENTAL

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

