

No. 2
4-13-40
5-17-39
I X23159

MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13942

Registration District No. 85

Primary Registration District No. 1001

State File No. _____
Registrar's No. 420

1. PLACE OF DEATH: BUCHANAN
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months, 1 day
In this community 2 mo. 1 day
years, months or days

2. USUAL RESIDENCE OF DECEASED: 11
(a) State Missouri (b) County Buchanan
(c) City or town St. Rural
(If outside city or town limits, write "RURAL") 0
(d) Street No. County Infirmary
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME C. Edward Hodge
(b) If veteran, name war _____
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 14
year 1941 hour 8 minute 35 P. M.

4. Sex male 5. Color or race colored
6. (a) Single, widowed, married, divorced. Single
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 16 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 13, 1941, to April 14, 1941;
that I last saw him alive on April 14, 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months 3 Days 28
If less than one day hr. _____ min. _____

Immediate cause of death Bronchopneumonia
(Organism Undetermined) Duration 14 days

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

Due to Encephalomalacia of Internal Capsule (Bilateral) about 1 month
Due to Arteriosclerosis

10. Usual occupation laborer

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name Anthony Hodge
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy Bronchopneumonia, Encephalomalacia of Internal Capsule (Bilateral)

14. Maiden name Nancy Duncan
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

16. (a) Informant Records State Hosp #2
(b) Address St. Joseph, Mo.
17. (a) BURIAL (b) Date thereof 4-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 85
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

(c) Place: burial or cremation St. H. Hosp. Burial
18. (a) Signature of funeral director Graves, F. W. Home
(b) Address 206 S. 17th St.

23. Signature D. P. Johnson (M. D. or other) M.D.
Address State Hosp #2 Date signed 4-15-41

19. (a) APR 17 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

St. Joseph, Mo

Not Embalmed

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 comply with the above constitutes grounds for revocation of license.)

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