

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

Registration District No. **784**

Primary Registration District No. **101**

Registrar's No. **1367**

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
 (c) City or town **University City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6668 Delmar Blvd.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Maude Hodgkins**

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

4. Sex **Female** / 5. Color or race **Wh**
 6. (a) Single, widowed, married, divorced. **Single**
 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 **About 72** Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace **St. Louis** **Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER FATHER

12. Name **Daniel Hodgkins**

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

14. Maiden name **11**

15. Birthplace **11**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Miss S. A. Nylander**
 (b) Address **824 Goodfellow Ave.**

17. (a) **Burial** (b) Date thereof **6/30/41**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Louis H Bopp, Inc**

(b) Address **131 W. Argonne, Kirkwood**

19. (a) **JUN 30 1941** (b) **W. R. Meyer, M.D.**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26** PM
 year **1941** hour **8** minute **45** AM

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 **Myocardial degeneration disease;
 Fatty degeneration of the liver;
 Generalized arteriosclerosis.**
 Due to _____
 Due to _____

Other conditions. **1/24/42**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **Yes**

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?

(Specify type of place) _____ (c) Means of injury _____
 23. Signature **Louis H Bopp, Inc** (M.D. or other) _____
 Address **Kirkwood, Mo., 6/28/41** Date signed _____

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

John M. Meyer

Licensed Embalmer No. *3288*

P. O. Address

*340 W. Adams
Kirkwood, 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, fact should be so stated above.