

1. PLACE OF DEATH:

(a) County Sullivan Clark Twp
(b) City or town Newton Rural
(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 _____ (Specify whether)
In this community Lifetime (Specify whether years, months or days)

8. (a) PRINT FULL NAME Jalie Ann Hodson

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race W 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 Aug. 21 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Sullivan County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Dress maker

11. Industry or business _____

12. Name John Hodson

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

14. Maiden name Jane Smith Stout

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

16. (a) Informant Mrs. Chas. Hall

(b) Address Newton Mo.

17. (a) Burial (b) Date thereof July 19 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton

18. (a) Signature of funeral director Judd & Payne

(b) Address Newton Mo.

19. (a) August 8 (b) Mrs. Ruth Tucker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Putman
(c) City or town Newton Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mile NW.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1941 hour 5:10 minute P. M.

21. I hereby certify that I attended the deceased from November 15, 1940, to July 18, 1941, that I last saw her alive on July 18, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of chest wall Duration 1 year

Due to _____

Due to _____

Other conditions 55
(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) (d) Means of injury _____

23. Signature W. J. Harris (M. D. or other) 280
Address Harris, Mo. Date signed 7/19/41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 8-4-1527

Date Filed AUG 15 1941

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 T. Howard Judd
Licensed Embalmer No. 3240
P. O. Address Newtown

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

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