

No. 2
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ca. 5120437

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 8 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 539

Primary Registration District No. 4318

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Laplata, Mo.
(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 all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town Laplata
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Maxim Hodges

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6 year 1942 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from Apr 20 to May 6 1942
that I last saw him alive on May 6 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race W.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary Katherine Hodges 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Aug 5 1863
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage

Due to Hypertention and arterio-sclerosis

Due to Bright's disease

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

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name Archabell Hodges

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

14. Maiden name Mary Katherine Hodges

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

16. (a) Informant G. P. Hodges

(b) Address Laplata, Mo

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

(c) Place: burial or cremation Hazel Dell

18. (a) Signature of funeral director G. B. Hopper

(b) Address Blairville Mo

19. (a) May 8-1942 (b) Olav B. Webber
(Date received local registrar) (Registrar's signature)

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 Ralph W. Tillet (M. D. or other) DD

Address Laplata Mo Date signed 5/14/42

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

1051

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10

RECEIVED
District Health Officer No. 10
District File Number 6-42-1198
Date Filed 2-1942

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 the above constitutes grounds for revocation of license.)

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

Registration District No. 532

Primary Registration District No. 4318

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town La Plata
(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.....
(Specify whether
In this community
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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

John M. Hodges

3. (b) If veteran,

name war.....

3. (c) Social Security

No.....

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Aug 5 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 14
If less than one day..... 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) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 13 Year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
..... 19.....

that I have seen him alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Bright's disease (chronic)
Due to.....

Due to.....

Other conditions.....
(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?

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

23. Signature Delphie Gilbert (M. D. or other) MD

Address La Plata Mo Date signed.....

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

(1000)