

FILED MAR

318

Registration District No. _____ Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 days**
(Specify whether
In this community **14 years**
years, months or days)

3. (a) PRINT FULL NAME **Ruth Hodge**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife **Andrew Hodge** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 1 1904**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 11 11 .hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **at home**

12. Name **Charles Smith**

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

14. Maiden name **Mary**

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

16. (a) Informant **Andrew Hodge**

(b) Address **3332 Lawton**

17. (a) **Burial** (b) Date thereof **Feb. 18 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **J. H. Harrison**

(b) Address **2906 Lawton**

19. (a) **FFB 17 1013** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis,** (If outside city or town limits, write "RURAL") **12**
(d) Street No. **3332 Lawton** (If rural, give location) **9 21**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **12,**
year **1943** hour **7** minute **55 P.** M.

21. I hereby certify that I attended the deceased from **January**
29, 19 **43** to **February 12,** 19 **43**
that I last saw her alive on **February 12,** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ca. of Cervix with metastases to Rectum and bladder**
Due to **Recto-Vesico Vaginal Fistula**

Other conditions (Include pregnancy within 3 months of death) **HO**

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 **C. R. Merry** (M.D. or other) _____
Address **2601 N. Whittier** Date signed **2/15/43**

Duration

2 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Arthur R. Hilliard

Licensed Embalmer No.

4221

P. O. Address

4219th E Garfield

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.