

Registration District No. 2

Primary Registration District No. 1000

Registrar's No. 78

FILED FEB 4/1944

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community Same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 706 west 44th
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Robert W. Hodge

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 Married

6. (b) Name of husband or wife Pearl A. Hodge

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

7. Birth date of deceased Oct 16th 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 2

If less than one day _____ hr. _____ min.

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

10. Usual occupation Electrical Engineer

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Hospital Records

(b) Address State Hospital # 2

17. (a) Removal (b) Date thereof 1-20-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo.

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Searson St. St Joseph Mo.

19. (a) 1-20-44 (b) Rose Helzsoy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18th year 1944 hour 2:30 minute P M.

21. I hereby certify that I attended the deceased from 1/11/44 to 1/18/44

that I last saw him alive on 1/18/44 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous meningitis

Duration 3 da

Due to 108

Other conditions hypertensive cerebral arterio sclerosis & nephritis

(Include pregnancy within months of death)

Major findings: _____

Of operations _____

Of autopsy Same

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) no

(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 Ed Paulsen (M. D. or other) _____

Address State Hospital # 2 Date signed 1/19/44

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 Albert R. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, 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.