

V.S. No. 2  
100M-8-43  
Rev. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 30 1944**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **31745**  
Registrar's No. **1961**

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis Manchester**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Pine Crest Nursing Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 Weeks** (Specify whether  
In this community **16 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis Manchester**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Pine Crest Home, Manchester, Mo.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **JAMES T. HODGES**  
3. (b) If veteran, name war **No**  
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept.** day **18th** 19  
year **1944** hour **1:00** minute **A** M.

4. Sex **M** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Rachel**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Dec. 3rd 1861**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**82** **8** **15** \_\_\_\_\_hr. \_\_\_\_\_min.

Immediate cause of death **From injuries received when struck by an automobile while a pedestrian on a public highway.**  
Due to **Fracture of skull; Subarachnoidal hemorrhage; subdural hemorrhage; multiple fractures of ribs of l. side.**

9. Birthplace **Tenn.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Hotel Clerk**  
11. Industry or business **Retired**

Due to **Fracture of skull; Subarachnoidal hemorrhage; subdural hemorrhage; multiple fractures of ribs of l. side.**  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **Yes.**

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
**1706-4**  
**21**

16. (a) Informant **Helen Gansner**  
(b) Address **2107 Russel Blvd.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/21/44.** (Month) (Day) (Year)  
(c) Place: burial or cremation **New St. Marcus Cem.**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **Accident.**  
(b) Date of occurrence **Sept. 18, 1944**  
(c) Where did injury occur? **1/3 mi. west of #141** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Public place**

18. (a) Signature of funeral director **A. W. McLaughlin**  
(b) Address **2301 Lafayette Ave.**  
19. (a) **SEP 25 1944** (Date received local registrar) (b) **J. M. Gurney, M.D.** (Registrar's signature)

While at work? **No.** (Specify type of place)  
(c) Means of injury **Struck.**  
**James J. Sisk, Coroner**  
Address **Clayton, Mo. 9-20-44** Date signed

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

16  
30

707

**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

*L. B. Craper*

Licensed Embalmer No.

*3633*

P. O. Address

*2317 Lafayette*

**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.**