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v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1947

Registration District No. 3179

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7250

Primary Registration District No. 3069

Registrar's No. 302

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7729 Weston Place
(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): 25 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis 96

(c) City or town: Richmond Heights 8
(If outside city or town limits, write "RURAL")

(d) Street No.: 7729 Weston Place 3
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: MAY HODGES

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex: F 1

5. Color or race: W

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

6. (b) Name of husband or wife: C. H. Hodges

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

7. Birth date of deceased: June (Month) 11 (Day) 1875 (Year)

8. AGE: Years 71 | Months 7 | Days 28 | If less than one day: 15 hr. 04 min.

9. Birthplace: St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Henry Todd
13. Birthplace: Unknown (City, town, or county) England 4 (State or foreign country)

MOTHER
14. Maiden name: Louise Hartmann
15. Birthplace: Unknown (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant: Mrs. T. P. Sorensen
(b) Address: 7729 Weston Place

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 12 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Valhalla Cemetery

18. (a) Signature of funeral director: Watson Bocklage
(b) Address: 6536 Clayton Rd.

19. (a) 2-11-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from Jan 19, 1946 to Feb. 9, 1947 and that death occurred on the date and hour stated above. I last saw him alive on Feb. 8, 1947

Immediate cause of death: Chr. Myocarditis

Due to: Senility 93 D

Due to:

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

Major findings:
Of operations:

Of autopsy:

Duration

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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: E. G. Williamson (M. D. or coroner)

Address: 6336 Clayton Road Date signed: 2/10/47

(Licensed Embalmer's Statement on Reverse Side)

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. J Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address.....

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.