

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

P. O. 24733

FILED JUL 29 1947
Registration District No. 187

Primary Registration District No. 3038

State File No. _____

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield

(c) Name of hospital or institution: Brookfield Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

In this community 7 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

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

(d) Street No. Locust Creek Township
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MANUEL MONROE HODGERSON

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month July day 17
year 1947 hour 12 minute 5 A.M.

4. Sex Mo 5. Color of race W

6. (a) Single, wid, or married Married
divorced None

21. I hereby certify that I attended the deceased from March 3 1947 to July 16 1947
that I last saw him alive on July 16 1947
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct-2-1913
(Month) (Day) (Year)

Immediate cause of death: Increased intracranial pressure

Duration 15 days

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>9</u>	<u>15</u>	min.

Due to Brown Tumor in Rt Frontal lobe

Due to _____

9. Birthplace New Boston Mo
(City, town, or county) (State or foreign country)

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

10. Usual occupation Farmer

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

12. Name Harve L. Hodgerson

13. Birthplace Sangamon Co Ill
(City, town, or county) (State or foreign country)

14. Maiden name Sadie Rennes

15. Birthplace Dallis Co Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Reef Hodgerson

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof July-19-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield Mo

19. (a) 7-18-47 (b) Walter Blinn
(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) _____ Means of injury 2

23. Signature Dr. J. P. Deem (Physician or other) _____

Address Brookfield Date signed 7/18/47

DISTRICT HEALTH OFFICE
Camden, Mo.

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. R. Blacklock

Licensed Embalmer No. *2246*

P. O. Address

Brookfield 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.