No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36646

FILED OCT 29 1947

Registration District No. 17

Primary Registration District No. 6076

Registrar's No. 2249

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 285 days (Specify whether years, months or days)
In this community 5½ years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 69
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2205 Delmar 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

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

4. Sex Female 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jake Hodges
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 2 (Day) 1911 (Year)

8. AGE: Years	Months	Days	If less than one day
36	3	20	hr. min.

9. Birthplace Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Chester Harris
13. Birthplace Mississippi (City, town, or county) (State or foreign country)
14. Maiden name Irma White
15. Birthplace Mississippi (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27/47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director F A Green
(b) Address 4214 Delmar Blvd
19. (a) 10-27-47 (Date received local registrar) (b) Cecil C Thompson (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 22 year 1947 hour 7 minute 35 P. M.
21. I hereby certify that I attended the deceased from 1-10- 1947 to 10-22- 1947; that I last saw her alive on 10-22- 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	16 mo. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 b

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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) 0
While at work? (e) Means of injury
23. Signature Bernard Freeman (M. D. or other) MD
Address Robt. Koch Hospital Date signed 10-23-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Gaylon H. Swan Registered Apprentice No. 101 working under my personal supervision.

Signed G. A. Greene

Licensed Embalmer No. 2963

P. O. Address 4214 DELMAR BL

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.