

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2870

BIRTH NO. _____		REG. DIST. NO. <u>93</u>		PRIMARY REG. DIST. NO. <u>5334</u>		Registrar's No. <u>19870</u>	
1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood R.F.D. 2</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood R.F.D 2</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>Calvin</u>		c. (Last) <u>Hodson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 6 1949</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 15, 1883</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Month <u>11</u> Day <u>21</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Dade Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Benton Hodson</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Carr</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Lane Courtney</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Frank Hodson</u>			ADDRESS <u>Lockwood, MO</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Streptococcal Meningitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>3403</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Infected prostate gland</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Lockwood Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-1-</u> , 19 <u>49</u> , to <u>4-6-</u> , 19 <u>49</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. D. Combs M.D.</u>				23b. ADDRESS <u>Lockwood Mo</u>		23c. DATE SIGNED <u>4-6-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 8, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo</u>	
DATE REC'D BY LOCAL REG. <u>4-7-49</u>		REGISTRAR'S SIGNATURE <u>Geo. S. Weir</u>		790		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Allison</u>	
						ADDRESS <u>Greenfield, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 6,

District File Number 449-449

Date Filed 4-11-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W R Allison

Licensed Embalmer No. 4404

P. O. Address Spencerfield, Va

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.