

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21620

FILED JUL 13 1950

State File No. _____
Registrar's No. **5682**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2259	
c. LENGTH OF STAY (In this place) 6 hrs.		d. STREET ADDRESS (If rural, give location) 1021 Franklin 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			

3. NAME OF DECEASED (Type or Print) Jackson			4. DATE OF DEATH (Month) (Day) (Year) June 28 1950		
a. (First)		b. (Middle)		c. (Last)	
				Hodge	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 2	8. DATE OF BIRTH Oct. 1, 1897	9. AGE (In years last birthday) 52	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY Printing	11. BIRTHPLACE (State or foreign country) Erin, Tenn. /	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Jim Hodge	13b. MOTHER'S MAIDEN NAME Frances Powers	14. NAME OF HUSBAND OR WIFE divorced
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) No	16. SOCIAL SECURITY NO. 499-05-1233	17. INFORMANT'S SIGNATURE OR NAME Herman Hodge	ADDRESS 912 Anglerodt St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) Tubercular Pneumonia		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? PO2X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:40 P. m.**, from the causes and on the date stated above.

22. SIGNATURE Patrick E. Taylor, 3rd (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 6.30.50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 1, 1950	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. JUN 30 1950	REGISTRAR'S SIGNATURE J. B. Lancaster	25. FUNERAL DIRECTOR'S SIGNATURE Suedmeyer & Sons	ADDRESS 3934 N. 20th St.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Mum

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Neville B. Kuchwetter*

Signed.....
Student Embalmer

Licensed Embalmer No. *3696*

P. O. Address *3934-N. 20th ST.*

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.