

FILED MAY 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18186
State File No. 4606

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ST. LOUIS, MISSOURI</u>)		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1</u>		STREET ADDRESS (If rural, give location) <u>213 South 3rd Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u> b. (Middle) c. (Last) <u>HODGES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 5 1951</u>
--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>Aug. 23, 1903</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-----------------	---------------------------	--	---------------------------------------	---	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PTD</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	---	------------------------------

13a. FATHER'S NAME <u>Elige Hodges</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Whittaker</u>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
---	-------------------------	-----------------------------------	---------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>chronic glomerulonephritis</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) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Laenne's cirrhosis</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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>592X</u>

22. I hereby certify that I attended the deceased from 4-10-51, 1951, to 5-5-61, 1951, that I last saw the deceased alive on 5-5-51, 1951, and that death occurred at 4:00A m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. Kuyasu M.D.</u>	(Degree or title)	23b. ADDRESS <u>1515 Lafayette Avenue</u>	23c. DATE SIGNED <u>5-5-51</u>
---	-------------------	--	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>10 MAY 17 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State)
---	------------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>MAY 17 1951</u>	REGISTRAR'S SIGNATURE <u>J. B. Lester</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service Inc.</u>	ADDRESS <u>1104 Manchester Ave. St. Louis 10, Mo.</u>
--	--	--	--

WRITE PLAINLY—USING UNFAADING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.

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.