

Health,  
Welfare  
Public  
Service

STANDARD CERTIFICATE OF DEATH

FILED JUN 28 1957

57-02-1-20  
STATE FILE NUMBER  
2671

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>RAYTOWN</u> 7000 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>RESEARCH HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>9712 EAST 69th STREET</u>	
Length of stay in 1b <u>10 DAYS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DORRIS</u> Middle <u>VERELLE</u> Last <u>HODGES</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1957</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-11, 1913</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CHEMICAL LAUNDRY SUPPLY CO.</u>	11. BIRTHPLACE (City and state or country) <u>COFFEYVILLE KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>GEORGE HODGES</u>	13b. MOTHER'S MAIDEN NAME <u>BERNIECE FOLAND</u>	14. NAME OF HUSBAND OR WIFE <u>DORIS HODGES</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>497-03-6303</u>	17. INFORMANT <u>Mrs. DORIS HODGES</u>	Address <u>9712 E. 69th ST. RAYTOWN, MO-</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>		<u>10 days</u>
• Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>congestive heart failure</u>	<u>3 days</u>
	DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	<u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4750</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm; factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>3 Mar 1955</u> to <u>6 June 1957</u> and last saw her alive on <u>6 June 1957</u> Death occurred at <u>5:30 P.M.</u> on the date stated above; and to the best of my knowledge from the causes stated.
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22a. SIGNATURE <u>Jack M. Davis M.D.</u> (Degree or title)	22b. ADDRESS <u>Raytown Mo</u>	22c. DATE SIGNED <u>6 June 57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 7 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>	ADDRESS <u>1331 BAUGHN CREEK K.C., MO-</u>	25. DATE RECD. BY LOCAL REG. <u>6-7-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.  
Jack M. Davis

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 .....  
Signature of Student Embalmer

Signed *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *CE No*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.