

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003073
STATE FILE NUMBER
2 690
Registration No.

FILED FEB 10 1959 Registration District No. _____ Primary Registration District No. _____

| | | | |
|---|-----------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY <i>ST. LOUIS</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>FLORISSANT</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i> | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) <i>17 ST. CHARLES ST</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>NELLIE</i> Middle <i>TRENE</i> Last <i>HODDE</i> | | | 4. DATE OF DEATH Month <i>JANUARY</i> Day <i>18</i> Year <i>1959</i> |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>OCT. 9, 1902</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <i>56</i> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____ Min. _____ |
| 11. BIRTHPLACE (City and state or country) <i>HERCULAEUM, MO.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13a. FATHER'S NAME <i>THOMAS SCAGGS</i> | | 13b. MOTHER'S MAIDEN NAME <i>HARRIET KNOX</i> | 14. NAME OF HUSBAND OR WIFE <i>FRED HODDE</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | 17. INFORMANT <i>MRS. JEAN PACINO, FLORISSANT MO</i> Address _____ |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION, SUSPECTED</i> DUE TO (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i>420.0</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 YEARS</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>HYPERTENSION, ESSENTIAL, ETIOLOGY UNKNOWN</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 |
| 21. I attended the deceased from <i>JAN. 23, 1959</i> to <i>JAN. 19, 1959</i> and last saw her alive on <i>JAN. 19, 1959</i> Death occurred at <i>6:55 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>C. K. Demillion, M.D.</i> (Degree or title) C M. D. | | 22b. ADDRESS <i>BARNES HOSPITAL</i> | 22c. DATE SIGNED <i>1/19/59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | 23b. DATE <i>1-21-59</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>ST. JOHN'S CEMETERY</i> | 23d. LOCATION (City, town, or county) (State) <i>GRANITE CITY, ILL.</i> |
| 24. FUNERAL DIRECTOR <i>THE FLORISSANT MORTUARY</i> | | 25. DATE RECD. BY LOCAL REG. <i>JAN 20 59</i> | 26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i> <i>mjb</i> |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57
W.S.

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 *Gene Hutchens*

Licensed Embalmer No. *4966*.....

P. O. Address *FLORISSANT, MO*

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.