

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022545

FILED JUL 13 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 161

STATE FILE NUMBER 1

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>24 hrs.</u>		c. CITY OR TOWN <u>Bridgeton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>11666 Mark Twain Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>B.</u> Last <u>Hodge</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6th</u> Year <u>1959</u>									
5. SEX <u>Female</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>9-30-1887</u>		9. AGE (last birthday) <u>71</u>					
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>		11. BIRTHPLACE (City and state or country) <u>Crawford Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Arthur Bray</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Stults</u>				14. NAME OF HUSBAND OR WIFE <u>George Sherman Hodges</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>unknown</u>		17. INFORMANT Address <u>Robert E. Herbert, 817 Victoria Pl. Glendale, Mo.</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>arterio sclerotic Cardio</u>		DUE TO (c) <u>vascular disease</u>		9 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
20d. INJURY OCCURRED WHILE AT WORK <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 <u>May 23-59</u> to <u>July 6-59</u> and last saw her <u>alive on July 6-59</u> Death occurred at <u>7</u> o <u>8</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Vernon R. Schneider MD</u>				22b. ADDRESS <u>St. Charles, Mo</u>				22c. DATE SIGNED <u>7/7/59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-9-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>JAY B. SMITH, Maplewood, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 7-59</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8881 7 3 100

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed f. Allen Davis
Licensed Embalmer No. 409

P. O. Address St. J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.