

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022999

STATE FILE NUMBER 5921
REGISTRAR NO. 5921

FILED JUL 2 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo.		d. STREET ADDRESS 5351 Delmar Blvd.	
3. NAME OF DECEASED (Type or print) First Middle Last Ida May Hodson		4. DATE OF DEATH Month Day Year 6 20 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 96
11. BIRTHPLACE (City and state or country) Randolph County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William D. Powell		13b. MOTHER'S MAIDEN NAME Matilda Frances Denom	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Masonic Home of Missouri- 5351 Delmar Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 450.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 week unknown
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 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 1-56 to 6-20-59 and last saw her alive on 6-20-59 Death occurred at 7:55 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold E. Walters M.D.		22b. ADDRESS 3720 Washington St. Louis Mo.	22c. DATE SIGNED 6-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-23-59	23c. NAME OF CEMETERY OR CREMATORY Hannibal, Missouri	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc. 4700 Washington		25. DATE RECD. BY LOCAL REG. JUN 22 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL INFORMATION ON THIS FORM MUST BE CAREFULLY RELATED.

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 *John B. ...*

Licensed Embalmer No. *3657*

P. O. Address *St. Louis, 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.