

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033905

FILED VS OCT 8 1959

2 8229

STATE FILE NUMBER

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

INDEXED

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | a. STATE Illinois | |
| Length of stay in 1b | | b. COUNTY Madison | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | c. CITY OR TOWN Troy | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 117 S. Main | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|-------------------------------------|--------|--------|------------------|-----|------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | |
| First | Middle | Last | Month | Day | Year | |
| GRETCHEN | ELAINE | HODAPP | SEPTEMBER | 5 | 1959 | |

| | | | | | | | | |
|------------------|---------------------------|---|-------------------------------|------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-22-1912 | 9. AGE (last birthday) 47 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|------------------|---------------------------|---|-------------------------------|------------------------------|---------------------------|------------------------|-------|------|

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|--|-----------------------------------|--|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Forest Hill, Mich. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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|--------------------------------------|--|--|
| 13a. FATHER'S NAME Elvin B. Hafer | 13b. MOTHER'S MAIDEN NAME Ethel Rearick | 14. NAME OF HUSBAND OR WIFE Eugene Hodapp |
|--------------------------------------|--|--|

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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) No | 16. SOCIAL SECURITY NO. unk | 17. INFORMANT Address Eugene Hodapp, 117 S. Main, Troy, Ill. |
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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) | CARDIAC FAILURE FOLLOWING MITRAL VALVOTOMY | 36 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS | 22 YEARS |
| | DUE TO (c) 410x | |

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| 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 |
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| 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 a.m. p.m. | Month, Day, Year |
|---|------------------|

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|--|--|--|
| 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 AUGUST 15, 1959 to SEPT. 5, 1959 and last saw her SEPT. 5, 1959
Death occurred at 2:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---------------------------------------|----------------------------|
| 22a. SIGNATURE (Degree or title) <i>H.R. Prudley</i> | 22b. ADDRESS M. D. BARNES HOSPITAL | 22c. DATE SIGNED 9/5/59 |
|---|---------------------------------------|----------------------------|

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|--|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 9-8-1959 | 23c. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cem. | 23d. LOCATION (City, town, or county) (State) Madison Co., Ill. |
|--|-----------------------|--|--|

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| 24. FUNERAL DIRECTOR Edwards Funeral Home, Troy, Ill. | 25. DATE RECD. BY LOCAL REG. SEP 5 1959 | 26. REGISTRAR'S SIGNATURE <i>Lois Smith, M.D.</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Not Embalmed*
Jewel S. Edwards

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 embalmed by a *STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.