

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-032339**

**FILED VS AUG 22 1960**

**318**

Primary Registration District No. **1003**

Registrar's No. **7360**

STATE FILE NUMBER

ENDED

|   |  |   |  |  |  |  |
|---|--|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Miller</b> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  | Length of stay in 1b  | c. CITY OR TOWN <b>Eldon</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis- Little Rock Hospitals, Inc.</b>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>R R #1</b>   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Mark</b> Middle <b>Lafayette</b> Last <b>Hodges</b>  |  |   | <b>4. DATE OF DEATH</b><br>Month <b>July</b> Day <b>23</b> Year <b>1960</b>  |  |  |  |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>White</b>  | <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/><br><b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>4-28-1896</b>  | <b>9. AGE (last birthday)</b><br><b>64</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Pensr. Locomotive Engineer</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Railroad</b>   | <b>11. BIRTHPLACE</b> (City and state or country)<br><b>SEDALIA, MO</b>  | <b>12. CITIZEN OF WHAT COUNTRY</b><br><b>U.S.A.</b>  |  |  |
| <b>13a. FATHER'S NAME</b><br><b>EDWARD W. HODGES</b>  |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><b>ANNA CAIN</b>  |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><b>Lois</b>  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES W.W.I.</b>   |  | <b>16. SOCIAL SECURITY NO.</b>  | <b>17. INFORMANT</b> Address<br><b>MRS. LOIS HODGES, RT1, ELDON, MO.</b>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure, chronic congestive</b><br>DUE TO (b) <b>arteriosclerotic heart disease</b><br>DUE TO (c) <b>4200</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>                                   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)   |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year  |  |   |  |  |  |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                | <b>20f. CITY, TOWN, OR LOCATION</b>   | <b>COUNTY</b>  | <b>STATE</b>   |  |  |
| <b>21. I attended the deceased from</b> <b>6-21-60</b> to <b>July 23, 1960</b> and last saw <b>him</b> alive on <b>July 22, 1960</b><br>Death occurred at <b>3.20 A.m</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |  |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><b>R.C. Treuman, M.D.</b>  |  |   | <b>22b. ADDRESS</b><br><b>1755 So. Grand Ave.,</b>   |  | <b>22c. DATE SIGNED</b><br><b>7/23/60</b>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Removal</b>  | <b>23b. DATE</b><br><b>July 25, 1960</b>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Memorial Park Cem.</b>  | <b>23d. LOCATION</b> (City, town, or county) (State)<br><b>Sedalia, Mo.</b>  |  |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><b>Gillespie Funeral Home Sedalia, Mo.</b>   |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><b>JUL 23 1960</b>   | <b>26. REGISTRAR'S SIGNATURE</b><br><b>Stan Smith, M.D.</b><br><i>m. g. p. 3</i>   |  |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 22 1960

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard D. Conn

Licensed Embalmer No. 4703

P. O. Address Sedalia, 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.