

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1960

-60-035845

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 23

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>O, Fallon</u>		c. CITY OR TOWN <u>O, Fallon</u>	
Length of stay in 1b <u>5 months</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>511 Westridge Dr</u>		d. STREET ADDRESS (If outside, give location) <u>511 Westridge dr.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>None</u> Last <u>Hodge</u>			4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>60</u>		
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5. SEX <u>Male</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>3/9/1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Detective</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad.</u>	11. BIRTHPLACE (City and state or country) <u>Arkansas Ouachita, county</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Clark Hodge.</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Dodge</u>	14. NAME OF HUSBAND OR WIFE <u>Tillie Mae Hodge</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>702-10-0685</u>	17. INFORMANT <u>John W. Hodge.</u> Address <u>O, Fallon Mo.</u>
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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: IMMEDIATE CAUSE (a) <del>Medullary Failure</del> <u>Metastasis of Malignant Tumor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
DUE TO (b) <u>Cancer of throat and mouth</u>		
DUE TO (c) <u>  </u>		
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 type="checkbox"/> N: <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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u> <u>  </u> <u>  </u>	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
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21. I attended the deceased from Sept 15, 1960 to Sept 30, 1960 and last saw him alive on Sept 30, 1960  
 Death occurred at 7:10 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold G. Mangord Do</u>	22b. ADDRESS <u>O Fallon Mo</u>	22c. DATE SIGNED <u>OCT 1, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>October 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>BUCHHOLZ MORT. - 5967 W. Florissant Ave</u>	25. DATE RECD. BY LOCAL REG. <u>10/3/1960</u>	26. REGISTRAR'S SIGNATURE <u>Ed Keithly</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8031713

OCT 10 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 Wilfred J. Buchholz

Licensed Embalmer No. 4551

P. O. Address St. Louis

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.