

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **10985**

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2377**

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

FILED MAR 23 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Saint Louis** Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **4171 Washington Blvd.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY
c. CITY OR TOWN **Saint Louis** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **4171 Washington Blvd.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Toney** Middle **C.** Last **Hodgins** 4. DATE OF DEATH Month **March** Day **8** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **11-24-1885** 9. AGE (last birthday) **75** IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **Pickens, Mississippi** 12. CITIZEN OF WHAT COUNTRY **U. S. A.**

13a. FATHER'S NAME **Sam Hodgins** 13b. MOTHER'S MAIDEN NAME **Zora Chambers** 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 17. INFORMANT Address **Mrs. Wilette Smith 3502 Cora Ave.**

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 Myocardial Infarction**
DUE TO (b) **Arteriosclerotic cardiovascular disease**
DUE TO (c) **420.1**
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

INTERVAL BETWEEN ONSET AND DEATH

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **Feb. 10, 1961** to **March 8, 1961** and last saw ^{her} him alive on **March 6, 1961**
Death occurred at **7:05 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **James H. Utley, M.D.** 22b. ADDRESS **4503 Page Blvd.** 22c. DATE SIGNED **3/10/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **3-14-61** 23c. NAME OF CEMETERY OR CREMATORY **Washington Park Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR **Metropolitan Funeral System, Inc.** ADDRESS **5010 Enright** 25. DATE RECD. BY LOCAL REG. **MAR 11 1961** 26. REGISTRAR'S SIGNATURE **Loan Smith, M.D.**

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 K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus Ave.

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.