

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029333

3835

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3835

FILED AUG 25 1961

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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Independence | |
| Length of stay in lb 2 wks. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hospital | | d. STREET ADDRESS (If outside, give location) 215 South Osage | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Edward Middle H. Last Hodkins | 4. DATE OF DEATH Month 7 Day 31 Year 1961 |
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| 5. SEX m. | 6. COLOR OR RACE w | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. AGE (last birthday) 78 81 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RET. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Illinois | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Jeromia Hodkins | 13b. MOTHER'S MAIDEN NAME MARGARETE Judy. | 14. NAME OF HUSBAND OR WIFE Elizabeth Hodkins |
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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 | 17. INFORMANT Mrs. Elizabeth Hodkins, 215 So. Osage |
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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) Arteriovascular Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH Unknown |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

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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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ |
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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 |
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21. I attended the deceased from **7-8-61** to **7-31-61** and last saw him alive on **7-30-61**
Death occurred at **10:45 p** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) J.P. McCalla, M.D. | 22b. ADDRESS Jackson Co Hospital Kansas City Mo. | 22c. DATE SIGNED 8-1-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8-3-1961 | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | 23d. LOCATION (City, town, or county) (State) Kansas City, Mo |
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| 24. FUNERAL DIRECTOR Floral Hills Mem. Chapel Inc | ADDRESS Floral Hills | 25. DATE RECD. BY LOCAL REG. 8-2-61 | 26. REGISTRAR'S SIGNATURE Ruth Long |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF P. MC CALLA MEDICAL CERTIFICATION

0108

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 C. M. Jansen

Licensed Embalmer No. 3453

P. O. Address B. C. Kari

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.