

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035306

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2609 STATE FILE NUMBER

AMENDED FILED SEP 27 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST JOHN</u>		Length of stay in 1b <u>20 YEARS</u>	c. CITY OR TOWN <u>ST. JOHN</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2835 RIDGEWAY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2835 RIDGEWAY</u>
3. NAME OF DECEASED (Type or print) First <u>ALVIA</u> Middle <u>RAY</u> Last <u>HODGE</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>13</u> - Year <u>61</u>	
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>11-15-01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WAGNER ELECTRIC</u>	9. AGE (last birthday) <u>59</u>
11. BIRTHPLACE (City and state or country) <u>SUNFIELD ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>KING HODGE</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA TERRY</u>	14. NAME OF HUSBAND OR WIFE <u>DOLLIE HODGE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>DOLLIE HODGE 2835 RIDGEWAY</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA of the rectum</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</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 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____ to _____ and last saw him alive on _____ Death occurred at <u>9-13-61</u> <u>5 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Arue E. Carlson M.D.</u> (Degree or title)		22b. ADDRESS <u>3109 Brown Rd 14th Mo</u>	22c. DATE SIGNED <u>9-15-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT LEBANON</u>	23d. LOCATION (City, town, or county) (State) <u>STANN MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>EARL HILLEMANN 9709 HACKBAND RD</u>		25. DATE RECD. BY LOCAL REG. <u>9-16-61</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>

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 Earl A. Schlemmer

Licensed Embalmer No. 3501

P. O. Address Brookland 14

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.