

S. No. 2
M-543
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33563

State File No.

FILED NOV 4 1947

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 290

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Anna Still Memorial Home #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether In this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Adair 999

(c) City or town Kirkville Keokuk. 13
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Thornton Lomax Hodge

3. (b) If veteran, name war WWI

3. (c) Social Security No.

4. Sex M 5. Color or race W

6. (a) widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 20 years (Day) (Year)

7. Birth date of deceased April 20 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49 6 6 hr. min.

9. Birthplace Keokuk Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe dealer

11. Industry or business

12. Name Hugh Campbell Hodge

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Annette M. Crain

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elean W. Carlson

(b) Address 25 Hillcrest Keokuk

17. (a) Removal (b) Date thereof 10 26 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keokuk, Iowa

18. (a) Signature of funeral director Summers & Powell

(b) Address 115-W - Jeff. St. Jeff. Keokuk, Mo.

19. (a) 10-26-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day twenty-sixth year 1947 hour one minute 16 A. M.

21. I hereby certify that I attended the deceased from Sept 12 1947, to October 26 1947; that I last saw him alive on October 25 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia, due to basal ganglia thrombosis + general cachexia

Due to Carcinoma of rectum, sigmoid colon and liver

Due to Amebic dysentery, amebic granuloma

Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations HOE

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury 2

23. Signature William C. Kelly (M.D. or other) MD

Address Kirkville, Missouri Date signed 10-26-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

8741 02 MMA

RECEIVED
District Health Officer No
District File Number 1147-12
Date Filed NOV-3 1947

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.....

James J. Taylor....., Registered Apprentice No. *436*
working under my personal supervision.

Signed *Robert B. Davis*.....

Licensed Embalmer No. *4219*.....

P. O. Address *Trenton, 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 this body is not embalmed, fact should be so stated above.