

SEP 26 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27731

1. PLACE OF DEATH

County St. Francois
Township
City Farmington, Mo. (No. State Hospital #A 4464)

Registration District No. 773
Primary Registration District No. 6078A

File No. 27731
Registered No. 124
St. _____ Ward _____

2. FULL NAME E. M. Hood

(a) Residence. No. Rombauer, Mo. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(write the word)

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 12th 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Mrs. Maud Hood.
(OR) WIFE OF

17. I HEREBY CERTIFY, That I attended deceased from May 28th 1930 to Aug. 12th 1930 that I last saw him alive on Aug 11 6:45 A.M. and that death occurred, on the date stated above, at _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1879 - ? - ?

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 ? ?

107A
78B
815
Apparitional Pneumonia
(Bacterial Pneumonia)
(duration) yrs. mos. 1.0 ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) Encephalitis following influenza some years ago. leaving Paralysis symptoms
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) P. S. Tate _____ M. D.
, 19 _____ (Address) Hosp #4 Farmington Mo.

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Hospital Records.
(Address) State Hospital #4, Farmington

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED 8-14-30 T. J. Robinson
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL 8/18/30
20. UNDERTAKER Harsh Taus
Body taken
None - by Wife ADDRESS Rombauer Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

