

FILED MAY 1940

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

15119
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson (b) Registration District No. 402
(c) Township Iron & Bar (d) Primary Registration District No. 5-5-513
(e) City Grain Valley (f) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(g) Length of residence in city or town where death occurred yrs. mos. ds. (h) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 892

2. PRINT FULL NAME

(a) Residence, No. 360 Nancy H. Hood
GRAIN VALLEY - RURAL St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John W. Hood
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 16, 1850
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 3 2
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retd. home wife
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER 13. NAME Kibner Stovall

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Nancy Hess

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Stella Fishback

18. BURIAL, CREMATION, OR REMOVAL PLACE Lee Summit DATE 4/20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. B. Webb
Cafe Grove Mo.

20. FILED Apr 20 1940 Mrs. A. H. Mance Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/18 1940
22. I HEREBY CERTIFY, That I attended deceased from 4/12 1940 to 4/18 1940
I last saw her alive on 4/18 1940 Death is said to have occurred on the date stated above, at 2:30 m.
The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia
Senility

Date of onset 4/15/40
1938

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Clint L. Miller, M. D.
Lee Summit, Mo. (Address)

N. B.—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.

STATE PRINTING WITH ORNAMENTING INK—THIS IS A PERMANENT RECORD

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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, _____

J. Webb _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____
Licensed Embalmer No. *2352*

P. O. Address *Oak Grove, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15-119

Registration District No. 402

Primary Registration District No. 5531B

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City of Iberia
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community years, months or days

3. (a) PRINT FULL NAME Nancy H. Hood
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex 7
5. Color or race W
6. (a) Single, widowed, married, divorced, wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 90 Months 3 Days 2
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH Month 4 day 18 year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on and that death occurred on the date and hour stated above

Immediate cause of death: Pneumonia, Brouchial Pneumonia
Duration: 1974

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
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
23. Signature Clint L. Miller (M. D. or other)
Address Lees Summit Date signed

SUPPLEMENTARY

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

PHYSICIAN
Underline the cause to which death should be charged statistically.

