

FILED DEC 7 1944

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 907

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 4 days 0
In this community 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Republic Rural
(d) Street No. _____
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME

Clyde H. Hood

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Macl Hughes Hood
6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased Mar. 16, 1883

8. AGE: Years 61 Months 8 Days -1 hr. _____ min. _____

9. Birthplace Republic (Rural) Mo.

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER { 12. Name Jas. D. Hood
13. Birthplace unk. Mo.
14. Maiden name Hanny Blades
15. Birthplace unk. Mo.

16. (a) Informant Mrs. Henry O. Bryant
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov. 19, 1944
(c) Place: burial or cremation Evergreen Cemetery

18. (a) Signature of funeral director R. E. Thuman
(b) Address Republic Mo.

19. (a) 11-18-44 (b) W. Standley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17
year 1944 hour 10:00 PM minute _____ M.

21. I hereby certify that I attended the deceased from Nov 4 1944 to Nov 17 1944
that I last saw him alive on Nov 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo Pneumonia Duration _____

Due to Pneumo Pneumonia

Due to _____

Other conditions _____

Major findings: _____

Of operations no operation

Of autopsy _____

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

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hospital
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature E. L. Beal (M. D. or other) _____
Address Republic Mo. Date signed 11/18/44

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

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, ^{and} or by.....
E. M. Thurman..... Registered Apprentice No. 3687
working under my personal supervision.

Signed E. M. Thurman.....
Licensed Embalmer No. 503.....
P. O. Address Republic 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.