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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 29 1944

Registration District No. 173

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33204

Primary Registration District No. 3036

Registrar's No. 94

1. PLACE OF DEATH:

(a) County: Lawrence

(b) City or town: Aurora Mo (Outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 231 W College (If not in hospital or institution, write street number or location)

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

In this community: 50 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Lawrence

(c) City or town: Aurora Mo (If outside city or town limits, write "RURAL")

(d) Street No.: 231 College St (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Isaac P. Ora Hood

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Jan (Month) 28 (Day) 1860 (Year)

8. AGE: Years 84 Months 5 Days 20 If less than one day hr. min.

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

10. Usual occupation: Teacher

11. Industry or business:

FATHER 12. Name: Eli Ora Hood

FATHER 13. Birthplace: Ind (City, town, or county) ( ) (State or foreign country)

MOTHER 14. Maiden name: Mary Hack

MOTHER 15. Birthplace: Ind (City, town, or county) ( ) (State or foreign country)

16. (a) Informant: Iona Oraood

(b) Address: 231 W College

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-18-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Springview

18. (a) Signature of funeral director: Brian L Marsh

(b) Address: Aurora Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1944 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from July 9, 1944, to July 16, 1944, that I last saw him alive on July 16, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Senility

Due to:

Due to: 162

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

Duration

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? (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: W. B. Herron (M. D. ~~or other~~)

Address: Aurora, Mo Date signed: July 18, 1944

1156

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1144-1161
Date Filed NOV 14 1944

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 Myself, Registered Apprentice No. —
working under my personal supervision.

Signed Oscar Harsh

Licensed Embalmer No. 3812

P. O. Address Aurora Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Alec

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 94

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Isaac P. Oakwood
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 28 (Day) 78 (Year)

8. AGE: Years 84 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Md. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 11-21-44 (Date received local registrar) (b) Eunice Green (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26 year 1944 hour day minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

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

Major findings:
Of operations
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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

38204