

FILED OCT 24 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 959

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days) In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt
(c) City or town Mound City
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lucy Hood

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lowell A. Hood 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased March 9 1921
(Month) (Day) (Year)

8. AGE: Years 24 Months 5 Days 27 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Grant Roach
13. Birthplace Holt Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Flossie Hord
15. Birthplace Henry Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Lowell A. Hood
(b) Address Mound City, Mo.

17. (a) removal (b) Date thereof 9/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound City, Mo.

18. (a) Signature of funeral director Be Lee Y Bowman

(b) Address 319 South 10th

19. (a) 9/6/45 (b) [Signature] (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th
year 1945 hour 1 minute 55 P. M.

21. I hereby certify that I attended the deceased from 9/5/45, 19, to 9/6/45, 19;
that I last saw him or alive on 9/6/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death: Rheumatic heart disease
Mitral stenosis

Due to Rheumatic fever

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 926
Of autopsy Same

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) Means of injury _____

23. Signature [Signature] (M. D. or other) Address St. Joseph 8, Mo. Date signed 9/7/45

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

1426

Dr. H. W. Carle
Phys. & Surg.

2/12/18
2/12/18

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address St. Joseph

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.