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FILED MAR 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7628

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mount Vernon, Mo</u>	
c. LENGTH OF STAY (in this place) <u>46 da</u>		d. STREET ADDRESS (If rural, give location) <u>209 S Vine</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>DAISY</u> b. (Middle) <u>Ellen</u> c. (Last) <u>HOOD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3-10-50</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-11-99</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Days <u>6</u> IF UNDER 24 HRS. Hours <u>29</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home-</u>		11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>ED HAZARD</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Wagoner</u>		14. NAME OF HUSBAND OR WIFE <u>Clyde Hood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u> ADDRESS _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PELVIC PERITONITIS, POST-OPER.</u>		II. OTHER SIGNIFICANT CONDITIONS <u>EPIDERMOID CA. UTERINE CERVIX, POST-IRRADIATION RECURRENCE</u>			<u>1 mo.</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>71X</u> <u>1 1/2 yrs</u>	

19a. DATE OF OPERATION <u>2-14-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>As above</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____		

22. I hereby certify that I attended the deceased from 1-23, 1950, to 3-10, 1950, that I last saw the deceased alive on 3-10, 1950, and that death occurred at 10:45P m., from the causes and on the date stated above.

23a. SIGNATURE (Degrees or title) <u>Richard E. Johnson, M.D.</u>		23b. ADDRESS <u>Columbia, Mo</u>		23c. DATE SIGNED <u>3-11-50</u>	
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/11/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>		24d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>March 3, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		31		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.O. Mellett Jr.</u> ADDRESS <u>Columbia</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
MAR 13 1950
District Health Officer No. 9,
District No.

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~~.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Lyman W. Sprunk

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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.