

FILED MAR 22 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9415

State File No. \_\_\_\_\_

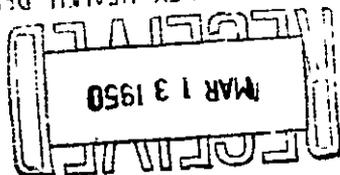
BIRTH NO. _____		REG. DIST. NO. <u>164</u>		PRIMARY REG. DIST. NO. <u>3022</u>		Registrar's No. <u>40</u>	
1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrensburg</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jefferson</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Warrensburg Hospital &amp; Clinic</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. #3, Knobnoster, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bertha</u>			b. (Middle) <u>Mildred</u>		c. (Last) <u>Hood</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 8, 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 30, 1880</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas E. Bagby</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Phillips</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd M. Hood</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Blanche Lassiter, Knobnoster, Mo.</u>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)							
<b>MEDICAL CERTIFICATION</b>							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Anoxemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
*This does not mean the mode of dying, such as heart failure, asthma, 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) <u>Cardiac decompensation</u>						<u>5 days</u>	
DUE TO (c) <u>Coronary Insufficiency</u>						<u>2 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.						<u>4201</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)		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 <u>3-5</u> , 19 <u>50</u> , to <u>3-8</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-8</u> , 19 <u>50</u> , and that death occurred at <u>5:40 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Stanton H. Kileox M.D.</u>				23b. ADDRESS <u>Warrensburg Hospital</u>		23c. DATE SIGNED <u>3/11/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial ( )</u>		24b. DATE <u>3-11-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Warrensburg, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>3/11/50</u>		REGISTRAR'S SIGNATURE <u>Barbara C. Cretney</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Warrensburg, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 22 1950

JOHNSON COUNTY HEALTH DEPT.



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.

Signed.....

A handwritten signature in dark ink, appearing to read "W. B. Brundage".

Signed.....  
Student Embalmer

Licensed Embalmer No. 3377

P. O. Address Waverly, 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.