

FILED JUN 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18965

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1356**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Bonhomme		c. LENGTH OF STAY (in this place) 8 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Weber Hill Rd RR#12 282		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Bonhomme	
		f. STREET ADDRESS (If rural, give location) Weber Hill Rd RR#12 Box 282	
3. NAME OF DECEASED a. (First) Claudia b. (Middle) Ireland c. (Last) Hood			4. DATE OF DEATH (Month) (Day) (Year) May 25 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 26 1897
		9. AGE (In years last birthday) 52	10. MONTHS 4
		11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? US
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME Joseph H Ireland		13b. MOTHER'S MAIDEN NAME Louisa M Desjardins	14. NAME OF HUSBAND OR WIFE Luke J Hood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME James J Hood RR12 Box 282 Kirkwood
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis of cerebral vessels DUE TO (c) vessels II. OTHER SIGNIFICANT CONDITIONS, Conditions contributing to the death but not related to the disease or condition causing death.	
		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X		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)	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 June, 1948 , to May, 1950 , that I last saw the deceased alive on May 25, 1950 , and that death occurred at 1:25 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Robert W. P. Cleaver M.D.		23b. ADDRESS P.O. Box 6 Sappington 23 Mo.	23c. DATE SIGNED 5/25/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-29-50	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St Louis County Mo.
DATE REC'D BY LOCAL REG. MAY 27 1950	REGISTRAR'S SIGNATURE Robert P. Cleaver M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Meyer-Pfizinger Kirkwood Mo.	

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

40000

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 *John M. Meyer*
Licensed Embalmer No. *3288*

P. O. Address *Kirkwood 22 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.