

FILED JUL 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23297

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REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 639

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY (br. St. Louis)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay	
c. LENGTH OF STAY (in this place) 201 Days		d. STREET ADDRESS (If rural, give location) 302 Vida	
d. FULL NAME OF HOSPITAL OR INSTITUTION O'Reilly VA Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Grover		b. (Middle) L.	
		c. (Last) Hood	
4. DATE OF DEATH (Month) (Day) (Year) July 16, 1950			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 8, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 57
			11. BIRTHPLACE (State or foreign country) St. Genevieve, Missouri
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ruby Hood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME O'Reilly VAH Records, Springfield, Mo.
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) Tuberculosis, chronic, far advanced, active pulmonary	
		INTERVAL BETWEEN ONSET AND DEATH	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) (Min.)	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 December 27, 1949 , to July 16, 1950 , and that death occurred at 5:55P m. , from the causes and on the date stated above.			
23a. SIGNATURE A.L. Bondurant, MD Acting Chief Professional Services Springfield, Missouri (Degree or title)		23b. ADDRESS O'Reilly VA Hospital, Springfield, Missouri	
23c. DATE SIGNED July 16, 1950			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/18/50	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. 7-17-50	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer ADDRESS Springfield, Mo.	

JAN 15 1953

AUG 3 1953

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Walter E Hamlet*

Signed.....
Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.