MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

[stamp] DEC 1 1939

39766
Do not use this space.

1. PLACE OF DEATH
(a) County Henry — Registration District No. 347
(b) Township Leesville — Primary Registration District No. 5501A — Registered No.
(c) City Coal — (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Josie Etoil Hood
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: Female — 4. COLOR OR RACE: White — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married	21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 16, 1939
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Robert Spencer Hood	22. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1939, to Nov 16, 1939. I last saw her alive on Nov 16, 1939. Death is said to have occurred on the date stated above, at ....m.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 16, 1877	The principal cause of death and related causes of importance were as follows: (Date of onset)
7. AGE: Years 62 — Months None — Days — If LESS than 1 day, ...hrs. or ...min.	Paresis. My conditions (acute) Kidney disease
OCCUPATION — 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housekeeper	
9. Industry or business in which work was done, as saw mill, bank, etc.	
10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co.	Other contributory causes of importance: Dehydration + Starvation + Fluids } unable to get food in patient
FATHER — 13. NAME Washington Bramell	Name of operation ... Date of ...
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin County	What test confirmed diagnosis? ... Was there an autopsy? ...
MOTHER — 15. MAIDEN NAME Louisa A. Cole	23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ... Date of injury ..., 19...
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin Co.	Where did injury occur? ... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.
17. INFORMANT F. A. Bramell (ADDRESS) Clinton Mo R#5	Manner of injury ...
18. BURIAL, CREMATION, OR REMOVAL Stone Chapel Cem. DATE Nov 19, 1939	Nature of injury ...
19. FUNERAL DIRECTOR (NAME) Howard L. Vansant (ADDRESS) Clinton Mo.	24. Was disease or injury in any way related to occupation of deceased? If so, specify ... (Signed) Geo. S. Wetzel, M.D.
20. FILED 11-27, 1939 Dr J R Hampton, Local Registrar.	(Address) Clinton, Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

RECEIVED
District Health Officer No. 7
District File Number 12-39-1660
Date Filed 12-12-39

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, ...
M. L. Canaan, or by .....

Registered Apprentice No. ✓, working under my personal supervision.

Signed M. L. Canaan

Licensed Embalmer No. 3779

P. O. Address Clinton 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39766
Do not use this space.

1. PLACE OF DEATH
(a) County Henry Registration District No. 347
(b) Township Leasville Primary Registration District No. 55-01A Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Josie Etol Hood
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62		1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE ,19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED , 19 *Local Registrar.*

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 16 ,19 39

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
I last saw h alive on , 19 . Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pateras Senile -	
Myocarditis acute	
Kidney Disease	
Coronary Sclerosis	1931

Other contributory causes of importance:
Dehydration + Starvation unable to get food + fluid as patient

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Jesse L. Welch , M. D.
(Address) Clinton Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's signature must be written CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.