

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**65-043692**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3033 Registrar's No. 284

**FILED DEC 6 1965**

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clinton</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Clinton</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>610 S. Orchard</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>610 S. Orchard</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>DELLA</b> Last <b>HOOD</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>25</b> Year <b>1965</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/2/86</b>
9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Montague Co Texas</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. NAME OF HUSBAND OR WIFE <b>Sherman Hood, Deceased</b>	
13a. FATHER'S NAME <b>Martin Luther Walrath</b>		13b. MOTHER'S MAIDEN NAME <b>Armintha Reading</b>	
14. NAME OF HUSBAND OR WIFE <b>Sherman Hood, Deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Lena Wilson, Clinton, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Paralysis</b> DUE TO (b) <b>Acute Myocardial Insufficiency</b> DUE TO (c) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a))			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>11-12-65</b> to <b>11-25-65</b> and last saw her/him alive on <b>11-25-65</b> . Death occurred at <b>7:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C. L. Glesper</b> (Degree or title)		22b. ADDRESS <b>Clinton, Mo.</b>	22c. DATE SIGNED <b>11/27/65</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 27, 65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Englewood</b>	23d. LOCATION (City, town, or county) (State) <b>Clinton, Mo.</b>
24. FUNERAL DIRECTOR <b>Consalus Clinton, M.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 29, 65</b>	26. REGISTRAR'S SIGNATURE <b>Mildred Bigums</b>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	DATE AMENDED	INSTEAD OF
1	10425	
2	20425	
3		
4	1	
5	2	
6		
7	1	
8	2	
9	420.1	
10		
11		
12	90-2	
13	1-2	

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5040  
5040

1-4  
-5

5-04

Permit Obtained 11-29-68 MS

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Eugene R. Conzalez

Licensed Embalmer No. 4680

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.