

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

Do not use this space.

17103

1. PLACE OF DEATH

County Wright Registration District No. 908
Township Mountain Grove Primary Registration District No. 222
City Mountain Grove

File No. _____
Registered No. 35
St. _____ Ward _____

2. FULL NAME

Sadie Hood
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) _____ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 | 7 | 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Prior, Long Co
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Luther Felix Hood

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Prior
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Mary Morris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Buehant
(STATE OR COUNTRY) Missouri

14. INFORMANT Daniel F Wood
(Address) Mountain Grove Mo

15. FILED 4/3 1929 J.H. Wood REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April - 2 - 1929

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 2, 1929 that I last saw him alive on April 1, 1929, and that death occurred, on the date stated above, at 10 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion
1185
155 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) H.G. James M. D.

4/3 1929 (Address) 10th Grove Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wood Cemetery DATE OF BURIAL April 3 1929
near Prior Mo

20. UNDERTAKER no ADDRESS _____

Should be carefully supplied. AGE should be carefully classified, so that it may be properly classified.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wright
Township Mt. Grove
City..... (No.) St. Ward)

Registration District No. 908
Primary Registration District No. 6222

File No.
Registered No. 2724

2. FULL NAME

Sadie Wood

(a) Residence. No. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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. ormin.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....
- (c) Name of employer.....

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED 4/3 1929 J.M. Hubbard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute indigestion
from diet
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGT should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-17103