

SEP 24 1940
Registration District No. 824

Primary Registration District No. 6076

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Shannon
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME Jessie New Hood 3rd

3. (b) If veteran, name war X 8. (c) Social Security No. X

4. Sex F 5. Color or race A 6. (a) Single, widowed, married, divorced -

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 21 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hr. 30 min.

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Montie Hood
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name Leta Randolph Mo
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Montie Hood
(b) Address Business Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Wood County

18. (a) Signature of funeral director Now 1744

(b) Address _____

19. (a) 8-22-40 (Date received local registrar) (b) Frank Bydo M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22
year 1940 hour 14 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Premature Birth

Due to _____

Due to 159
10-1

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank Bydo (M. D. or other) !

Address Business Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10-39
7-39
X21492

RECEIVED

District Health Officer No. 5,

District File Number. 940957

Date Filed _____

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 _____

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

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.