

MAR 18 1937

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

Do not use this space.

1. PLACE OF DEATH

34 County Springfield
Township and Butler
City Springfield (No. _____)Registration District No. 7957
Primary Registration District No. 53965File No. 5716
Registered No. 5716
St. _____ Ward _____

2. FULL NAME

Bessie E. Blinto(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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 24, 18727. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 1 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer _____9. BIRTHPLACE (CITY OR TOWN) Albany
(STATE OR COUNTRY) Springfield, Mo.10. NAME OF FATHER Joseph Blinto11. BIRTHPLACE OF FATHER (CITY OR TOWN) Albany
(STATE OR COUNTRY) _____12. MAIDEN NAME OF MOTHER unnamed13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Albany
(STATE OR COUNTRY) _____14. INFORMANT R. M. Raper
(Address) Wagoner Ave15. FILED Feb. 18, 1937 Faye Thornton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 2, 193717. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1936, to Feb. 2, 1937, and that I last saw him alive on Feb. 19, 1936, and that death occurred, on the date stated above, at Albany, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broken Hip from Fall
caused from Pericarditis
duration

CONTRIBUTORY (SECONDARY)

Pericarditis (duration) - yrs. 2 mos. 15 days

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH HomeDID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? specimen
(Signed) Dr. J. A. Osborn M. D., 19 (Address) Wagoner R-1

*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

Livingston
Lab. Osborn

DATE OF BURIAL

Feb 2, 1937

20. UNDERTAKER

ADDRESS

Wagoner Ave

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.

