

REC'D AUG 24 1938

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

25516

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398

(b) Township _____ Primary Registration District No. 3019

(c) City Independence (d) Street No. 824 S. Crysler St. _____

(e) Length of residence in city or town where death occurred 0 yrs. 4 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Dorothy Blair 460

(a) Residence, No. 824 S. Crysler St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1 - 3 - 0 - 1859

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

79	5	23	
----	---	----	--

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

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) Coldwater Mich.

13. NAME Sherman Westfall

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record Penn.

15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record No Record

17. INFORMANT Mrs. Besse Minor.
(ADDRESS) 1451 Curtis St. Denver, Colo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lamoni, Iowa DATE 7-26-1938

19. FUNERAL DIRECTOR H. W. Stahl.
(ADDRESS) 815 W. Maple Ave. Indep. Mo.

20. FILED 7-27-1938 J. L. Cook
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7 - 23 - 1938

22. I HEREBY CERTIFY That I attended deceased from March 31, 1938, to July 23, 1938.
 I last saw her alive on July 23, 1938. Death is said to have occurred on the date stated above, at 8:05 P. m.
 The principal cause of death and related causes of importance were as follows:
Congestive heart failure Date of onset 9:30 P. m.
Edema of the lungs

Other contributory causes of importance: _____

Name of operation no Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no, 19____
 Where did injury occur? home (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury home

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) John P. Berger M. D.
 (Address) Independence, Mo.

Dr J R Green

111a

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

_____ Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

255-16

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Independence Primary Registration District No. 3019 Registered No. 200
(c) City Independence (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 Mrs Dorothy Blair

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) 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.
79 5 23

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.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-23-1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 1935, to _____, 1935.

I last saw h. _____ alive on _____, 1935. 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:

Coronary Heart Failure
Chronic myocardial insufficiency.
Edema of lungs

Other contributory causes of importance:

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 _____, 1935

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) John R. Green, M. D.
(Address) Independence Mo

