

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.

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

3434  
Do not use this space.

1. PLACE OF DEATH

(a) County Fulton Registration District No. 718  
(b) Township 2 Primary Registration District No. 6830 Registered No. 8  
(c) City Unionville (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

(a) Residence, No. 130 Rebecca Abbott St. Unionville Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 20 - 1843

7. AGE YEARS 96 MONTHS 0 DAYS 28 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home work  
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) Mason Mo (STATE OR COUNTRY) Mo

FATHER 13. NAME Samuel Blanch 14. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) 1

MOTHER 15. MAIDEN NAME Mary Hunkeler 16. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) 1

17. INFORMANT Amel R. Cullum (ADDRESS) 609 W. Hubbard St. Fairfield Ia

18. BURIAL, CREMATION, OR REMOVAL PLACE Lawson DATE Jan. 21 1940

19. FUNERAL DIRECTOR (NAME) F. O. Hubert & Son (ADDRESS) Unionville Mo.

20. FILED Jan 18 1940 W. S. Allen Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18 - 1940

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:

V 70 1

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 \_\_\_\_\_, 19\_\_\_\_

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) \_\_\_\_\_, M. D.

(Address) 145

RECEIVED

District Health Officer No. 10

District File Number 2-40-283

Date Filed FEB 5 1940

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,

Murl E. Husted

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

Murl E. Husted

Licensed Embalmer No. 2504

P. O. Address

Amorville, 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

3434

Do not use this space.

1. PLACE OF DEATH

(a) County Putnam

Registration District No. 718

(b) Township Monroe

Primary Registration District No. 6430

Registered No. ....

(c) City Monroe

(d) Street No. ....

(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

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

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

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

7

4. COLOR OR RACE

W

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

wid

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.

96

0

28

OCCUPATION

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)

13. NAME

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

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 Jan 18 1940 H. W. Gellum  
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-18, 19 40

22. I HEREBY CERTIFY, That I attended deceased from

19... to ... 19...

I last saw h. .... alive on ... 19... 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:

Fracture of hip n.m.b.

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

Vascular disease

Chronic disease

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