

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11915**
Registrar's No. **5**

Registration District No. **5364**

Primary Registration District No. **644**

1. PLACE OF DEATH:

(a) County **Ozark Co**
(b) City or town **Lutia Rural Mayron**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME **Blaine Haskins 252**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Bertha May** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **Jan. 13 1887**
(Month) (Day) (Year)

8. AGE: Years **53** Months **0** Days **2** If less than one day hr. min.

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

10. Usual occupation **Farming**

11. Industry or business

12. Name **H. H. Haskins**

13. Birthplace **Ozark Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Laura Harper**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Loyell Haskins**
(b) Address **Lutia, Mo.**

17. (a) **Burial** (b) Date thereof **2-19-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Thornfield**

18. (a) Signature of funeral director **Chas. Kingbeards**
(b) Address **Quincy Mo.**

19. (a) **Mar 12 1940** (b) **Nathaniel H. Daniel**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ozark**
(c) City or town **Lutia**
(If outside city or town limits, write "RURAL")
(d) Street No. **8**
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **15**
year **1940** hour **3** minute **P.M.**

21. I hereby certify that I attended the deceased from **19** to **19**;
that I last saw him alive on **Feb. 15** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Apoplexy

Due to **Hypertension**

Due to **42**

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? **Yes** (Specify type of place) (e) Means of injury

23. Signature **M. C. Bentley** (M. D. or other) **1**
Address **Quincy Mo.** Date signed **3-8-40**

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

RECEIVED

District Health Officer No. 6,

District File Number 2440-1153

Date Filed APR 15 1940

Dr. M.C. Gentry

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.