

Registration District No. 801

Primary Registration District No. 6044

1. PLACE OF DEATH

(a) County Saline
(b) City or town Rural Salt Pond
(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 _____ (Specify whether _____)
In this community Life years, months or days _____

3. (a) PRINT FULL NAME EDWARD BLAKELY

3. (b) If veteran, name war 3. (c) Social Security No. 1-11-11

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

6. (b) Name of husband or wife ALICE BLAKELY 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased FEB 10, 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farmer of Soil

12. Name W. BLAKELY

13. Birthplace PA
(City, town, or county) (State or foreign country)

14. Maiden name MARIE L. LOCKNEY

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

16. (a) Informant Mrs. Herculia

(b) Address La Monte Mo

17. (a) Rural (b) Date thereof 9-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Autocast Burial

18. (a) Signature of funeral director A. C. Carter

(b) Address Sweet Spring Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Rural Salt Pond
(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 31
year 1940 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Sept 30, 1938 to 1940

that I last saw him alive on Aug 31, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomposition

Due to arteriosclerosis

Due to _____

Other conditions chronic nephritis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 121

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? Yes

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

23. Signature Leburn B. Ellis (M. D. or other) _____
Address Sweet Spring Mo Date signed 9/2/40

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

7

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-10-40

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 *R. C. Carter*

Licensed Embalmer No. 3573

P. O. Address *Street*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29785**
Registrar's No. **24**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **801**

Primary Registration District No. **6044**

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

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Salt pond**
(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.
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Edward Blakely

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **m** 5. Color or race **w**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **76** Months **6** Days **21** If less than one day .h. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **9/2/40** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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 **31** year **1940** hour minute 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

Due to

Due to

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 **Coburn Ellis** (M. D. or other) Address **Sweet Springs** Missouri

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

