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MAR 19 1941

State File No. _____

Registration District No. 565

Primary Registration District No. 5761a

Registrar's No. 53

1. PLACE OF DEATH: *Muller*

(a) County _____

(b) City or town *Alman, Mo.*
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Miller Co.*

(c) City or town *Alman, Mo.*
(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.

3. (a) PRINT FULL NAME *JOHN FRANKLIN BLIZE*

3. (b) If veteran, name war *no*

3. (c) Social Security No. *none*

4. Sex *Male*

5. Color or race *white*

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

6. (b) Name of husband or wife *Saddie (Jeffries) Blize*

6. (c) Age of husband or wife if alive *77* years

7. Birth date of deceased *Oct. 19 - 1861*
(Month) (Day) (Year)

8. AGE: Years *79* Months *4* Days *14* If less than one day hr. _____ min. _____

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

10. Usual occupation *Farmer*

11. Industry or business _____

12. Name *William Blize*

13. Birthplace *Muller Co. Mo.*
(City, town, or county) (State or foreign country)

14. Maiden name *Carolina Stokes*

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

16. (a) Informant *Saddie Kallen*

(b) Address *Alman, Mo.*

17. (a) *Burial* (b) Date thereof *3-4-1941*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Alman, Mo.*

18. (a) Signature of funeral director *C. Busey*

(b) Address *Alman, Mo.*

19. (a) *March 5, 1941* (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* day *2* year *1941* hour *6* minute *P* M.

21. I hereby certify that I attended the deceased from *Sept. 12, 1940* to *Mar. 2, 1941*; that I last saw him alive on *Feb. 27, 1941*; and that death occurred on the date and hour stated above.

Immediate cause of death *Pneumonia Bronchial*
Due to *chronic asthma*

Due to _____

Other conditions *107*
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations *none*

Of autopsy *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *no*

(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? *no*

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

23. Signature *C. J. Mallick* (M. D. or other) _____
Address *Alman, Mo.* Date signed *3-2-41*

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

MOTHER FATHER

RECEIVED

Miller County Health Dept.

County File Number

41-38

Date Filed

3/18/41

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

Ch. Basey

Registered Apprentice No.

working under my personal supervision.

Signed

Ch. Basey

Licensed Embalmer No.

7694

P. O. Address

Iberia, 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9601

Registration District No. 565

Primary Registration District No. 3761

Registrar's No. 53

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

1. PLACE OF DEATH:

(a) County Mollev
(b) City or town Blaine T.P.
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John Franklin Blize

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 79 Months 4 Days 14 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mar. 5 1941 (b) C. R. Hawkins (Date received local registrar) (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 Mar day 2
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ 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 Cyrus Mallette (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

