

FILED APR 9 1945

Primary Registration District No. 6162

Registrar's No. 75

I. PLACE OF DEATH:

(a) County Vernon
 (b) City or town Washington Township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
State Hospital No 3 Nevada, Mo
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Nine days
 (Specify whether
 In this community
 years, months or days) 9 0 0

8. (a) PRINT FULL NAME F. O. BLOOD

8. (b) If veteran, name war Not Known No. None

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

6. (b) Name of husband or wife Mrs F. O. Blood 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Not Known
 (Month) (Day) (Year)

8. AGE: Years 80 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Stone Cutter

11. Industry or business

MOTHER FATHER
 12. Name Not Known
 13. Birthplace Not Known 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Not Known
 15. Birthplace Not Known 9
 (City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records
 (b) Address Nevada, Mo

17. (a) Burial (b) Date thereof Mar 6 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richland, Mo

18. (a) Signature of funeral director Longs Funeral Service
 (b) Address Nevada, Mo

19. (a) 3-5-44 (b) Allen V. Hays
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede MO
 (c) City or town Lebanon
 (If outside city or town limits, write "RURAL")
 (d) Street No. Not Known
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
 year 1941 6 hour 20 minute A. M.

21. I hereby certify that I attended the deceased from Feb 25th 1941 to March 5th 1941
 that I last saw him alive on March 5th 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerotic Heart Disease

Due to 92 H
 Due to

Other conditions Senile Psychosis
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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?
795
 While at work? (Specify type of place) (e) Means of injury

23. Signature G. S. Warwick (M. D. or other)
 Address State Hospital No 3 Nevada Date signed 3/5/44

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

1800

RECEIVED

District Health Officer No. 7,

District File Number 4-41-618

Date Filed 4-7-41

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Allen E. Kays

Licensed Embalmer No. 1968

P. O. Address Nevada 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 875-

Primary Registration District No. 6162

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Washington 710
(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 _____

years, months or days)

3. (a) PRINT FULL NAME Franklin Blood

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 _____ year

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

8. AGE: Years 80 Months _____ Days _____
If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/5/41 (b) Allen V. Hayes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Laclede
(If outside city or town limits, write "RURAL")

(d) Street No. 741 K...
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5
year _____ 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 G. S. Warach (M. D. or other) _____

Address Nevada Date signed _____

SUPPLEMENTARY

