

No. 2
4-13-40
5-17-39
X23150

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20463

State File No. _____

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 5275

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No. Baptist Hospital ()
(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 Arthur Franklin Blanton

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, Child

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

7. Birth date of deceased Nov. 13 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>7</u>	<u>13</u>	hr. _____ min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Melvin Kieffer

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

14. Maiden name Mildred Jaeger

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

16. (a) Informant Mrs. Mildred Blanton

(b) Address Sullivan, Mo.

17. (a) Removal (b) Date thereof 6/26/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 700 Washington Ave.

19. (a) JUN 26 1941 (b) J. T. Probert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36

(c) City or town Sullivan
(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 June day 24 30
year 1941 hour 9³⁰ minute 9 M.

21. I hereby certify that I attended the deceased from June 24 1941 to June 25 1941
that I last saw him alive on June 25, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria

Due to _____

Due to _____

Other conditions Acute appendicitis
(Include pregnancy within 3 months of death)

Major findings: Acute appendicitis
Of operations _____
Of autopsy Infiltration of terminal ileum - Ross Peyle patches

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? _____
(Specify type of place) (e) Means of injury _____

23. Signature E. J. Taylor (M. D. or other) _____
Address 462 N. Taylor Date signed _____

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.....

Wesley H. Burnley

Licensed Embalmer No. 4302

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, fact should be so stated above.

Registration District No. 10

Primary Registration District No. 10

Registrar's No. 5275

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Methodist
(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)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Arthur F. Beanton
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month June day 24 year 41
hour _____ minute _____ M. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Typhoid Fever Duration _____

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

8. AGE: Years 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 (City, town, or county) (State or foreign country)

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) 8-1-41 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: acute appendicitis
Of operations: appendectomy 6-24-41
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

