

FILED SEP 9 1943
Registration District No. 27

Primary Registration District No. 410.2

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Creighton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: SI
(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 Mo (b) County Cass 19
(c) City or town Creighton 0
(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.

8. (a) PRINT FULL NAME Frank Cloud Blossom

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

7. (b) Name of husband or wife Myra Blossom 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased August 26 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 11 19 hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name O. P. Blossom

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

14. Maiden name James Goodspeed

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

16. (a) Informant Mrs Myra Blossom
(b) Address Creighton Mo.

17. (a) Burial (b) Date thereof 8-17-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ann's
(d) Signature of funeral director Robert Arnold

(b) Address Creighton Mo.
19. (a) 8/16/1943 (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 15
year 1943 hour 3:30 minute PM

21. I hereby certify that I attended the deceased from Aug 1, 1943, to Aug 15, 1943
that I last saw him alive on 8-15, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma ✓

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 A. W. Smoland (M. D. or other) DO
Address Urish, Mo Date signed 8-16-43

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 *Robert Arnold*

Licensed Embalmer No. *3621*

P. O. Address *Creechton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 59

Primary Registration District No. 4102

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Creighton
(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 Frank Claud Blosson

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 sm

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

7. Birth date of deceased aug 26 1882
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Data 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 26 Year 1943 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 carcinoma
left temple
Primary site unknown
Due to _____

Due to _____

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

Major findings: Of operations _____ 53

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 A. W. Morland (M. D. or other) D.O.

Address _____ Date signed _____

SUPPLEMENTAL

MOTHER FATHER

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

157

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