

FILED MAR 13 1944

Registration District No. 200

Primary Registration District No. 5723

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Macon

(b) City or town rural cheritonny
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(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 Macon 61

(c) City or town rural
(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) PRINTED FULL NAME James H. Blew

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 6
year 1944 hour 1 minute 15 A.M.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Sarah E. Blew

6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased March 8 1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 4 1944
5:00 to Feb 6 1944
that I last saw him alive on Feb 6 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Croupis Pneumonia Duration _____

8. AGE: Years 83 Months 10 Days 29
If less than one day _____ hr. _____ min.

Due to Heart complication

Due to _____

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

10. Usual occupation Retired Farmer

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

Major findings: _____

Of operations _____

Of autopsy no

11. Industry or business _____

12. Name Willis Blew

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

14. Maiden name Margaret King

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Elmo Blew

(b) Address College Mound, Mo. P.R. 1

17. (a) Burial (b) Date thereof 2-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hebron Cem. Macon Co

18. (a) Signature of funeral director Stephen Goodies Mo

(b) Address Macon Mo

19. (a) 2/4/44 (b) J. B. Hunkler
(Date received local registrar) (Registrar's signature)

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 0

23. Signature J. L. Strippeer (M. D. or other) _____

Address College Mound Mo Date signed 2-6-1944

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-44-573

Date Filed MAR 10 1944

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.....

O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.