DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1944

Registration District No. 712

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. ~~712~~ 5780

State File No. 25190

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Eldon, Mo. R.D. No 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: At Home Sat and Sun
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 1 Year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller 66

(c) City or town Rural, Eldon, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. R.D. No. 1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Betty Lou Blankenship

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May 27 - 1935
(Month) (Day) (Year)

8. AGE: Years 9 Months 2 Days 4 If less than one day hr. min.

9. Birthplace Jefferson City, MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name W. R. Blankenship
13. Birthplace Miller County, MO 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mable O. Slone
15. Birthplace Miller County, MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. M. Slone
(b) Address Eldon, Mo. R.D. No 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2-44
(Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Clyde Morton
(b) Address Box 144 Eldon, MO

19. (a) 8-1-44 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st year 1944 hour 10 minute 25 M.

21. I hereby certify that I attended the deceased from 7/29, 1944 to 7/31, 1944 that I last saw her alive on 7/31, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Abscess of Brain	3 days
Due to Cerebrospinal meningitis	2
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature G. D. Walker (M.D. or other)

Address Eldon Mo Date signed 7/31/44

1114

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Miller County Health Dep't
County File Number 44-69
Date Filed 7-5-44

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 205690

Registration District No. 212 Primary Registration District No. 5780 Registrar's No. 39

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Rural Salem Twp

(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 years, months or days)

In this community

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 Betty Lou Blankenship

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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

7. Birth date of deceased May (Month) 27 (Day) 1944 (Year)

8. AGE: Years 9 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 3, year 1944 hour A.M. 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 Meningitis

Due to Pneumococcus

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

81a

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)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

25190