

No. 2
5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27509

State File No. _____

FILED SEP 8 7 1944

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 118

1. PLACE OF DEATH:

(a) County... Clay

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

(c) Name of hospital or institution:
Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution... 1 day
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 2.4

(a) State... Missouri (b) County... Clay 1

(c) City or town... Excelsior Springs,
(If outside city or town limits, write "RURAL") 1

(d) Street No. 104 Outlook St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country... _____ 1

3. (a) PRINT FULL NAME Mollie Elizabeth Bland

3. (b) If veteran, name war... None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced... 2

6. (b) Name of husband or wife _____

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

7. Birth date of deceased... February 7th 1873
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG, day 9
year 1944 hour 8: minute 15 A. M.

21. I hereby certify that I attended the deceased from July 27
1944 to Aug 9 1944
that I last saw her alive on Aug 9 1944
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
71	6	2	hr. _____ min.

Immediate cause of death... chronic myositis.

Due to Tuberculosis - asthma

Due to _____

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

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George Stonum

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

14. Maiden name Celle Duncan

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

16. (a) Informant Beulah Laveland

(b) Address Raymour, Missouri

17. (a) Burial (b) Date thereof Aug. 11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Mo.

19. (a) 8-11-44 (b) Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations 0

Of autopsy no

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) no

(b) Date of occurrence no

(c) Where did injury occur? no
(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 J. M. Coakley (M. D. or other) MD
Address Excelsior Springs Mo Date signed 8/10/44

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

RECEIVED

District No. 1011

District No. 1011

Date Filed 9-7-47

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

Carl Rapp

Licensed Embalmer No. 3458

P. O. Address St. Louis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Excelsior Springs Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 wk (Specify whether)

In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Mellie E. Blankenship

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W

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

6. (b) Name of husband or wife _____

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

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

8. AGE: Years 71 Months 62 Days 13 (If less than one day)

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

10. Usual occupation Aug.

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) _____ (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) _____ (b) Mrs. Sadie Redman (Date 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 year 1944 day _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Myocarditis?

Due to Tuberculosis

arteritis

Due to (lungs) S.P.M.

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

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? _____

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature S.P.M. Corbett (M. D. or other) W.S.

Address Excelsior Springs, Mo. Date signed 9/12/44

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

SUPPLEMENTAL

27509