

V. S. No. 2  
FORM-8-43  
Rev. 5-17-39  
X37823

31898

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED SEP 20 1944

Registration District No. 336

Primary Registration District No. 4494

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County SHANNON

(b) City or town WINONA  
(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 1  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon

(c) City or town Winona 100  
(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 GEORGE BLAKESMORE

3. (b) If veteran, name war NO

3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Oct 16 1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1944 hour 6PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from JAN-1-1925 to Aug 8 - 1944 19\_\_\_\_ to 19\_\_\_\_; that I last saw him alive on Aug 8 - 1944 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Natural Causes

Due to \_\_\_\_\_

Due to Pulmonary Tuberculosis 4 yrs.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: 78 years 10 months 23 days  
UNKNOWN / 865 Oct 11.

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

12. Name UNKNOWN

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

14. Maiden name unknown

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

16. (a) Informant H.E. ENTERMAN

(b) Address WINONA MO

17. (a) \_\_\_\_\_ (b) Date thereof 9-6-44  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winona Mo

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address None

19. (a) 9-6-44 (b) Frank H. Hyde MD  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature W. J. Ballman MD (M.D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 1

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

101  
2  
0

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

984491

9-16-44

1944

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SHARON  
AMONIA

GEORGE J. BAKER

NO

WIFE

SHARON  
AMONIA

STATEMENT BY LICENSED EMBALMER

FARNER

SHARON

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.....

H. E. FARNER  
AMONIA

Licensed Embalmer No.....

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.