V. S. No. 2
50M—[illegible]
Rev. 5-17-39
I X32873

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

FILED OCT 13 1944

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31928

State File No.

Registration District No. 359 Primary Registration District No. 6220 Registrar's No. 20

1. PLACE OF DEATH:

(a) County ~~[illegible]~~ Vernon Harrison Twp

(b) City or town Arcadia, Kansas. R F D.
(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
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon

(c) City or town Arcadia, Kansas. R F D
(If outside city or town limits, write "RURAL")

(d) Street No. Harrison Twp.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Marshall Joseph Blinco

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M 0

5. Color or race W

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

6. (b) Name of husband or wife Uva Blinco

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased April (Month) I (Day) 1883 (Year)

8. AGE: Years 61 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Arcadia, Kansas. R F D, 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Geo Blinco, Deceased.
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emma White
15. Birthplace Unknown 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Dell Loist
(b) Address Arcadia, Kansas. R F D,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5- 22-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Worsley Cemetery

18. (a) Signature of funeral director N. T. Moonehan
(b) Address Arcadia, Kansas.

19. (a) 9-20-44 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1944 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 19, 44, May 20, 1944 to May 20, 1944
that I last saw him alive on May 20, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 1 Day

Due to Unknown

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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (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 T. R. Spell (M. D. or other)
Address Liberal MO Date signed 5/19/44

1519

(Licensed Embalmer's Statement on Reverse Side)

RE[illegible]

[illegible] Officer No. 7,

[illegible] 9-44-1184

Date [illegible] 10-12-44

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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed H. T. Moonehan

Licensed Embalmer No. 3616

P. O. Address Arcadia, Kansas

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.