No. 2
-9-4-41
5-17-39
X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

27128

State File No.

FILED SEP 6 1945

Registration District No. 1 Primary Registration District No. 5289 Registrar's No. 73

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

**1. PLACE OF DEATH:**

(a) County Clay

(b) City or town Rural - Gallatin Tw (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: #5 - North Kansas City Mo (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 yrs (Specify whether

In this community 10 yrs (years, months or days) Beauregard Blythe

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Clay 24

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

(d) Street No. #5 - North Kansas City Mo (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country NO

3. (a) PRINT FULL NAME Beaure Gard Blythe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Mo 0

5. Color or race Wht

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 Aug (Month) 22 (Day) 1865 (Year)

8. AGE: Years 80 Months 0 Days 8 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Retired

FATHER
12. Name Geo Blythe
13. Birthplace (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace ~~Joseph Lept~~ (City, town, or county) (State or foreign country) 9

16. (a) Informant Joseph Lept Blythe

(b) Address #5 No. K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North Kansas City Mo

19. (a) Sept 1st 1945 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 30 year hour 12 minute A.M.

21. I hereby certify that I attended the deceased from June 1945, to Aug 30, 1945 that I last saw him alive on Aug 29, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cardiovascular renal syndrome | 8 months |
| Due to age | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 3/6 | |
| 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)

(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 Wm H Goodson (M. D. or other) MD

Address Liberty Mo Date signed 8/30/45

1711

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-5-43

**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 John S Mitten

Licensed Embalmer No. 4349

P. O. Address .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 73

**1. PLACE OF DEATH:**

(a) County Clay

(b) City or town Rural Gallatin 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

3. (a) PRINT FULL NAME Bedure G. Blythe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Mrs Margaret Blythe

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

7. Birth date of deceased Aug 22 (Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 0 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

FATHER 12. Name

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

MOTHER 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) Beulah Kitchen (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 3 year 1941 hour minute M.

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

Immediate cause of death — Duration

Due to

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)

(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

S-27128