

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 4 1945
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30321

State File No. _____

Registration District No. 5-8

Primary Registration District No. 5212

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Carter
(b) City or town Van-Buren (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at home / Carter home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 1
years, months or days

3. (a) PRINT FULL NAME

Joseph H. Blyze

3. (b) If veteran, name war _____

(c) Social Security No. _____

4. Sex MO
5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 22 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 14
If less than one day _____ hr. _____ min.

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

10. Usual occupation Common Laborer

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Social Security record

(b) Address Van Buren

17. (a) Burial (b) Date thereof 9-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Van Buren

18. (a) Signature of funeral director Seaton Pewitt

(b) Address Van Buren MO

19. (a) Sept 15 (b) Mrs Octa Henson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Carter
(c) City or town Van Buren rural
(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 Sept day 6 year 1945 hour 3 minute 30 P.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 Cardiac Failure Duration _____

Due to arterial hypertension

Due to Bright's Disease

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Seaton Pewitt (M.D. or other) Cor.

Address Van Buren Date signed 9-7-45

NOV 19 1958

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

Seaton Dewitt

Licensed Embalmer No.

2287

P.O. Address

Van Buren

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.

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. 267
Registrar's No. 21

Registration District No. 58

Primary Registration District No. 5212

1. PLACE OF DEATH:
(a) County Carter
(b) City or town rural Carter township
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Joseph H. Blyze
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race en
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased may 22 1945
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days _____ If less than one day _____ hr. _____ min. mo

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

10. Usual occupation _____

11. Industry or business _____

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) _____
(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 _____ Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

Due to chronic nephritis
Due to 131h

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____
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

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

30321