

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35823

State File No. _____

FILED NOV 13 1946

Primary Registration District No. 6173

Registrar's No. _____

1. PLACE OF DEATH

(a) County Shannon
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff 1
(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 Minnie Elizabeth Bland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W
6. (a) Name of husband or wife Richard Bland 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased apr 24 - 1897
(Month) (Day) (Year)

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

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

10. Usual occupation Buf

11. Industry or business _____

12. Name R. B. McDaniel

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

14. Maiden name McDaniel

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

16. (a) Informant Richard Bland

(b) Address Ellington Mo. Rt-

17. (a) Burial (b) Date thereof 12 - 13 - 46
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Spring Haven Cemetery

18. (a) Signature of funeral director John Owens

(b) Address Mo & Owens

19. (a) 11-1-46 (b) W. B. Ramey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon 131
(c) City or town Rural, Barlowe Twp 0
(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 Oct day 11
year 1946 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from Oct 10
1 1946 to Oct 11 1946
that I last saw him alive on Oct 11 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Disability Military 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:

(c) 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 Frank Hyde (M. D. or other) _____

Address Reveries Date signed 11-13-46

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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

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.