

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5523**

FILED MAR 12 1947

Registration District No. **227**

Primary Registration District No. **4339**

Registrar's No. **13**

1. PLACE OF DEATH:

(a) County **MONROE**
 (b) City or town **PARIS**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
WASHINGTON & RUBEN STS.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 YRS**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **LILLIE MAY BLANTON**

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

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **MAR 17, 1865**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	10	14	hr. min.

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

10. Usual occupation **AT HOME**

11. Industry or business

MOTHER FATHER

12. Name **BENJ. F. BLANTON**

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

14. Maiden name **HARRIETTE YOUNG**

15. Birthplace **BOONE Co., Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **H. J. BLANTON**

(b) Address **PARIS, MO.**

17. (a) **BURIAL** (b) Date thereof **FEB 5, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WALNUT GROVE**

18. (a) Signature of funeral director **Speed Blakely**

(b) Address **PARIS, MO.**

19. (a) **3-3-47** (b) **Elbert Baker M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **MONROE**
 (c) City or town **PARIS**
(If outside city or town limits, write "RURAL")
 (d) Street No. **WASHINGTON & RUBEN STS**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB.** day **3**
 year **1947** hour **9** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **DEC 2**, 19**46** to **FEB 3**, 19**47**
 that I last saw him alive on **FEB 3**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
 Duration **20X**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93D**

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?

While at work? (Specify type of place) or means of injury **0**

23. Signature **Geo M. Seale** (M. D. or other)

Address **PARIS, MO.** Date signed **2-7-47**

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

200

RECEIVED
District Health Officer No. 1
District File Number 2647-4
Date Filed MAR 11 1947

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..... *E. H. Agnew*

Licensed Embalmer No. 4000

P. O. Address..... Paris, Missouri.

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.