

No. 2
5-43
17-39
X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5888

Registration District No. 310

Primary Registration District No. 6051

Registrar's No. 20

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town "Rural" St. Charles Twsp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R. R. 2 /
(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 Edward Blann
3. (b) If veteran, name war NIL
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Latonia (Rodgers) Blann
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased September 29 1887
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace Livingston Co., Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Barber

11. Industry or business _____
12. Name Blann
13. Birthplace Livingston Co., Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lewis
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Latonia Blann
(b) Address R.R. 2-St. Charles, Mo.
17. (a) burial (b) Date thereof Feb 9-1947
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Immanuel Evang. Cem Weldon Springs, Mo.

18. (a) Signature of funeral director H. L. Dillmeyer & Sons, Inc.
(b) Address 800 N. 2nd-St. Charles, Mo.
19. (a) 2-10-47 (b) Fannie Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town Weldon Springs
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (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 7
year 1947 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 Coronary Thrombosis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy no

Duration _____
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 3
23. Signature Marie Dillmeyer (a) D. or Other _____
Address Weldon Springs Date signed 1-7-47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 2-18-47

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.....

Herbert C. Dallmeyer Registered Apprentice No. *429*
working under my personal supervision.

Signed *Joseph T. Landwehr*
Licensed Embalmer No. *4189*
P. O. Address *St. Louis*

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.

Registration District No. 310 Primary Registration District No. 10051

1. PLACE OF DEATH

(a) County St Charles
(b) City or town rural
(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

Edward Blann

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 M

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 29

(month) (day) (Year)

8. AGE:

Years

Months

Days

If less than one day

59

4

mo

hr. _____ min.

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) _____

(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) Feb 10 - 47

(Date received local registrar)

(b) Janie Hammett

(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 _____ Day _____
Year 1948 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 _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-5888