

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

9944

State File No.

FILED APR 9 1947
 Registration District No. 207

Primary Registration District No. 4319

Registrar's No. 18

1. PLACE OF DEATH:
 (a) County Maries
 (b) City or town Belle
 (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..... Life
 years, months or days)

3. (a) PRINT FULL NAME Wm. Earnest Blankenship

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased Dec 1st 1883
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 3 21 ..hr.min.

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

10. Usual occupation Farmer

11. Industry or business.....

12. Name W. J. Blankenship

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

14. Maiden name Loumonia Brumble

15. Birthplace Cooper Hill MO
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Belle Swartz

(b) Address Belle Mo

17. (a) Burial (b) Date thereof 3-24-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Red Cemetery

18. (a) Signature of funeral director W. J. Blankenship

(b) Address Lincoln Mo

19. (a) 3-29-47 (b) Pauline Howard
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Maries 63
 (c) City or town Belle Mo 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. (If rural, give location) 0
 (e) Citizen of foreign country?..... (Yes or No) 0
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 22
 year 1947 hour 5 minute 00 pp.

21. I hereby certify that I attended the deceased from 3/10/47 to 3/20/47
 that I last saw him alive on 3/20/47
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Influenza 2wks.

Due to

Other conditions (Include pregnancy within 3 months of death) 94A

Major findings: Of operations

Of autopsy.....

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 R. H. Schenck M. D. or other DD
 Address Belle Mo Date signed 3/26/47

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

MOTHER FATHER

188

(Licensed Embalmer's Statement on Reverse Side)

Date Filed 4/8/47
District File Number

District Health Officer No. 9,

RECEIVED

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 Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Leam

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.