

FILED JUN 10 1947

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Dixon r.d.
(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 Lamina Blankenship

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

4. Sex Female 5. Color or race White 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 Dec 30 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 4 29 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name John Brumble
13. Birthplace S. Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Nanct Jane Carnes
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Willis Blankenship

(b) Address Eldon Mo

17. (a) Burial (b) Date thereof 5-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Symoria Cemetery

18. (a) Signature of funeral director Clide M. Mott

(b) Address Linn Mo

19. (a) 5-4-47 (b) Pauline J. Norman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Maries
(c) City or town Dixon R.D.
(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 5 day 29
year 1947 hour 4 minute 00 p.m.

21. I hereby certify that I attended the deceased from May 15 1947 to May 27 1947
that I last saw her alive on May 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac dilation and de-
compensation Duration 12 days

Due to
Due to

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?

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

23. Signature Donley Gates (M.D. or other) Do.
Address Dixon, Mo Date signed 5-31-47

RECEIVED
District Health Officer No. 8
District File Number
Date Filed

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. Minton*
Licensed Embalmer No..... *4125*
P. O. Address..... *Levin*

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.