

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **20019**

FILED JUL 7 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. **4009**

Registrar's No. **178**

1. PLACE OF DEATH:

(a) County... **Andrew**

(b) City or town... **Savannah**  
(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... **13 yrs**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **MD** (b) County... **Andrew**

(c) City or town... **Savannah**  
(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: \_\_\_\_\_

3. (a) PRINT FULL NAME **EMMA L. BLAIR**

3. (b) If veteran, name war... **no**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **22** year **1947** hour **12** minute **20 a.**

4. Sex... **F**

5. Color or race... **W**

6. (a) Single, widowed, married, divorced... **Widowed**

6. (b) Name of husband or wife... **Robert Blair**

6. (c) Age of husband or wife if alive... **18 yrs**

7. Birth date of deceased... **4** (Month) **18** (Day) **18** (Year)

21. I hereby certify that I attended the deceased from **6 June 1947** to **27 June 1947** that I last saw her alive on **21 June 1947** and that death occurred on the date and hour stated above.

Duration **unknown**

8. AGE: Years **81** Months **2** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death... **Chronic Myocarditis, Arteriosclerosis, Hypertension**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace... **Oregon** (City, town, or county) **MD** (State or foreign country)

10. Usual occupation... **Homemaker**

Other conditions... **93D**  
(Include pregnancy within 3 months of death)

11. Industry or business... **Home**

12. Name... **Andrew Neesham**

13. Birthplace... **Unknown Ohio** (State or foreign country)

14. Maiden name... **Mary Pinner**

15. Birthplace... **Baltimore Maryland** (State or foreign country)

16. (a) Informant... **John Blair**

(b) Address... **Savannah MD**

17. (a) **Burial** (b) Date thereof... **6-24-47** (Month) (Day) (Year)

(c) Place: burial or cremation... **Savannah MD**

18. (a) Signature of funeral director... **Morris Atkinson**

(b) Address... **Savannah MD**

19. (a) **6-24-47** (Date received local registrar) (b) **Harold Spark** (Registrar's signature)

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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (Specify type of injury)

23. Signature... **Harold Spark MD** (M. D. or other) \_\_\_\_\_

Address... **Savannah MD** Date signed **6/24/47**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

2  
1  
0

**DISTRICT HEALTH OFFICE**  
**Canton, Mo.**

**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.**