

1. PLACE OF DEATH:

(a) Country General Wash. Ins
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 78 yrs 7 months 21 days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME CHARLES BLYTHE

8. (b) If veteran, name war L 8. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife L 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased 2-28-1869
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Clifton City, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Wm Blythe
13. Birthplace Ky
14. Maiden name Mary Fitch
15. Birthplace Maryland

16. (a) Informant Self

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 2-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Kays Funeral Service

(b) Address Nevada, Mo

19. (a) 2-9-48 (b) Walter Hickey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Casper
(c) City or town Unknown
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb day 15
year 1948 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from 11-9-1948 to 2-1-1948; that I last saw alive on 1-31-1948, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease

Due to arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 99%
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? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Walter Hickey (M. D. or other) _____
Address Nevada, Mo Date signed 2-1-48

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

08
9

District Health Officer No. 7,

District File Number 1-48-65

Date Filed 2-16-48

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 Allen J. Hayes

Licensed Embalmer No. 1968

P. O. Address Nevada M

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, above space should be left blank.