

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 1248
206

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson 41</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>2 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u>		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Osteopathic Hospital</u> 0				d. STREET ADDRESS (If rural, give location) <u>R R # 4</u> 1					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Blanche</u>			b. (Middle) <u>L.</u>		c. (Last) <u>Fritch</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 14 49</u>		
5. SEX <u>F /</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 7, 1890</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mo</u> 0		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>D.C. Vincent</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Dawson</u>			14. NAME OF HUSBAND OR WIFE <u>Will Fritch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Will Fritch R R# 4 Independence, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralytic Ileus</u> ANTECEDENT CAUSES <u>Hypertensive cardio-vascular renal syndrome.</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Hypertension & cerebral accident.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>5 yrs.</u> <u>3 days</u>	
19a. DATE OF OPERATION <u>1/13/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Indep. Rt. 4 Jackson Mo. 49</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 11 1949 m.</u>			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down the steps at her home.</u>							
22. I hereby certify that I attended the deceased from <u>1/11/49</u> , 19____, to <u>1/14/49</u> , 19____, that I last saw the deceased alive on <u>1/13/49</u> , 19____, and that death occurred at <u>5:26 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>F.W. Thompson</u> (Degree or title)				23b. ADDRESS <u>705 Bryant Bldg, K.C. Mo.</u>			23c. DATE SIGNED <u>1-14-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1/17/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo</u>			
DATE REC'D BY LOCAL REG. <u>1-17-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE & McCLURE 3235 GILLHAM PLAZA</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

W. F. Thompson
Bangor, Me.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Robert W. Reed

Licensed Embalmer No. 3744

P. O. Address H. P. Inc

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.