

FILED APR 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11634
State File No.

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 140

1. PLACE OF DEATH a. COUNTY Butler			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Butler		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Polar Bluff		c. LENGTH OF STAY (in this place) 40 Years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		
d. FULL NAME OF HOSPITAL OR INSTITUTION 101 Marshal			d. STREET ADDRESS (If rural, give location) 101 Marshal		
3. NAME OF DECEASED a. (First) Maudie b. (Middle) Bloodworth c. (Last) Bloodworth			4. DATE OF DEATH (Month) (Day) (Year) 4 11 49		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10/7 1888		9. AGE (In years last birthday) 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Shannon County		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Wills		13b. MOTHER'S MAIDEN NAME Minerua Canrol		14. NAME OF HUSBAND OR WIFE William Bloodworth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Bloodworth Poplar Bluff Mo.		
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac failure DUE TO (c) Cardiovascular renal disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5617			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 4-1-49	19b. MAJOR FINDINGS OF OPERATION Vertical Strangulated Umbilical Hernia			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Poplar Bluff Butler Mo		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR OH		
22. I hereby certify that I attended the deceased from 4-10-49 , 19 49 , to 4-11-49 , 19 49 , that I last saw the deceased alive on 4-11-49 , 19 49 , and that death occurred at 2P m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) W. N. Johnson M.D.		23b. ADDRESS Poplar Bluff Mo		23c. DATE SIGNED 4-18-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/15/49	24c. NAME OF CEMETERY OR CREMATORY Bay Springs		24d. LOCATION (City, town, or county) (State) Butler County Mo.	
DATE REC'D BY LOCAL REG. April 20, 1949	REGISTRAR'S SIGNATURE W. N. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE Frank Estell		ADDRESS Poplar Bluff, Mo.	

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

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APR 25 REC'D

BUTLER COUNTY HEALTH CENTER

449-65

4-25-49

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. 474

working under my personal supervision.

Signed

John M. Davies

Signed.....
Student Embalmer

Licensed Embalmer No. 4620

P. O. Address

Poplar Bluff, Mo.

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.