

FILED JUL 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22454**

BIRTH NO. _____ REG. DIST. NO. **335** PRIMARY REG. DIST. NO. **4492** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY OR TOWN ORAN		c. CITY OR TOWN ORAN 1100	
c. LENGTH OF STAY (in this place) 49 yrs		d. STREET ADDRESS (If rural, give location) ORAN 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Guardian Angels Church			

3. NAME OF DECEASED (Type or Print) THERESA			a. (First)		b. (Middle) BLAES		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) MAY 30 1950				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH October 25 1865			9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 6	IF UNDER 1 YEAR Days 7	IF UNDER 1 YEAR Hours 0	IF UNDER 1 YEAR Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY In Own Home				11. BIRTHPLACE (State or foreign country) New Hamburg, Mo. 0			12. CITIZEN OF WHAT COUNTRY? U. S. A.		

13a. FATHER'S NAME Louis Bucker		13b. MOTHER'S MAIDEN NAME Elizabeth Morper		14. NAME OF HUSBAND OR WIFE John P. Blaes	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. Bryon Wade		ADDRESS Benton, Mo.	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						4/31X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Just before death**, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE Clude Pol 3 Bureau Director mo		23b. ADDRESS		23c. DATE SIGNED 6/15/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 2 1950		24c. NAME OF CEMETERY OR CREMATORY Old Guardian Angels		24d. LOCATION (City; town, or county) (State) Oran Scott Mo.	
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DATE REC'D BY LOCAL REG. 6/26/50		REGISTRAR'S SIGNATURE Frank J. MacCune		25. FUNERAL DIRECTOR'S SIGNATURE Carl J. Smith		ADDRESS Oran, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED **JUL 10 1950**

SCOTT COUNTY HEALTH CENT

CO. FILE NO. 750-7

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Earl J. Smith

Signed.....
Student Embalmer

Licensed Embalmer No. 3676

P. O. Address Oren, 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.