

FILED JUL 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25850

BIRTH NO. _____ REG. DIST. NO. 358 PRIMARY REG. DIST. NO. 6212 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Bacon Twp</u>		c. LENGTH OF STAY (In this place) <u>3 1/2 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Schell City, Rural, Bacon Twp</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) <u>Lee</u> c. (Last) <u>Blakely</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 1 1950</u>
5. SEX <u>male</u>	6. COLOR, OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 27 1867</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. MONTHS <u>0</u>	11. DAYS <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Easton, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Lee Blakely</u>	
13b. MOTHER'S MAIDEN NAME <u>Bessie Mary Crouse</u>		13. NAME OF HUSBAND OR WIFE <u>Belle Bell Lyon</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 <u>Belle Blakely Schell City, 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>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> ANTECEDENT CAUSES DUE TO (b) <u>arteriosclerosis</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic Hypertrophy</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>none Performed</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	
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? _____	
22. I hereby certify that I attended the deceased from <u>6/5, 1950</u> , to <u>7/1, 1950</u> , that I last saw the deceased alive on <u>6/30, 1950</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M.D. Bjork, D.O.</u>		23b. ADDRESS <u>Rockville, Mo.</u>	23c. DATE SIGNED <u>7/2/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 2, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Schell City, Mo.</u>
DATE REC'D BY LOCAL REG. <u>July 1-1950</u>	REGISTRAR'S SIGNATURE <u>Mrs Sarah E Gray</u> 329	25. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis & Son</u> ADDRESS <u>Schell City, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

1080

DIVISION OF HEALTH OF MD.

District No. 5 - Springfield

RECEIVED JUL 14 1950

Dist. File 750-794

Date Filed 7/14/50

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.

Signed Marion M. Lewis

Signed _____
Student Embalmer

Licensed Embalmer No. 3084

P. O. Address Schell City, Md.

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.