

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 265481

FILED SEP 8 1950

|                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| BIRTH NO. _____                                                                                                                                                                                                                 |  | REG. DIST. NO. 117                                                                                                                                                                                                                                                                                                                                                                                                                   |  | PRIMARY REG. DIST. NO. 5436                                                                                                     |  | Registrar's No. 6                                                                   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Gasconade                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Gasconade |  |                                                                                     |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Boulware Twp                                                                                                                                 |  | c. LENGTH OF STAY (In this place) lifetime                                                                                                                                                                                                                                                                                                                                                                                           |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Boulware Twp.                                |  | 0370                                                                                |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Owensville, Mo. Route 2                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | d. STREET ADDRESS (If rural, give location) Owensville, Mo. Route 2                                                             |  |                                                                                     |  |
| 3. NAME OF DECEASED<br>(Type or Print) Ida                                                                                                                                                                                      |  | a. (First)                                                                                                                                                                                                                                                                                                                                                                                                                           |  | b. (Middle) Mathilda                                                                                                            |  | c. (Last) Blinne                                                                    |  |
| 5. SEX female                                                                                                                                                                                                                   |  | 6. COLOR OR RACE white                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single                                                                   |  | 8. DATE OF BIRTH Sept. 8, 1881                                                      |  |
| 9. AGE (In years last birthday) 68                                                                                                                                                                                              |  | 10. MONTHS                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country) Owensville, Mo.                                                                       |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                 |  |
| 13a. FATHER'S NAME Charles Blinne                                                                                                                                                                                               |  | 13b. MOTHER'S MAIDEN NAME Carolina Brinkmann                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. NAME OF HUSBAND OR WIFE                                                                                                     |  |                                                                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no                                                                                                                                                            |  | 16. SOCIAL SECURITY NO. ***                                                                                                                                                                                                                                                                                                                                                                                                          |  | 17. INFORMANT'S SIGNATURE OR NAME Clarence Blinne Owensville, Mo.                                                               |  |                                                                                     |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatoid Arthritis<br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Chronic myocarditis<br>DUE TO (c) renal nutrition<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |                                                                                                                                 |  | INTERVAL BETWEEN ONSET AND DEATH<br><br>4222                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                          |  | 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  | 20. AUTOPSY?<br>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) (Min)                                                                                                                                                                           |  | 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 10-1-50, 1949, to 8-12-50, 1950, that I last saw the deceased alive on 8-1-50, 1950, and that death occurred at _____ m., from the causes and on the date stated above.  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  |                                                                                     |  |
| 23a. SIGNATURE (Degree or title) Charles Blinne                                                                                                                                                                                 |  | 23b. ADDRESS Owensville, Mo.                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23c. DATE SIGNED 8-16-50                                                                                                        |  |                                                                                     |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                |  | 24b. DATE 8-16-1950                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24c. NAME OF CEMETERY OR CREMATORY Zoar Methodist Cem.                                                                          |  | 24d. LOCATION (City, town, or county) (State) Drake, Mo.                            |  |
| DATE REC'D BY LOCAL REG. 8/16/50                                                                                                                                                                                                |  | REGISTRAR'S SIGNATURE [Signature]                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature]                                                                                    |  | ADDRESS OWENSVILLE                                                                  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

File No. \_\_\_\_\_

DISTRICT HEALTH OFFICE No. 4

SEP - 4 1950

RECEIVED

### 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.....

Student Embalmer

Signed.....

*Murphy N. H. White*

Licensed Embalmer No. 3838

P. O. Address OWENSURIE

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.