

FILED MAY 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13198

BIRTH NO. _____ REG. DIST. NO. 182 PRIMARY REG. DIST. NO. 3040 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	c. LENGTH OF STAY (In this place) 83 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	
d. FULL NAME OF HOSPITAL OR INSTITUTION 400 Bridge St.		d. STREET ADDRESS (If rural, give location) 400 Bridge St.	

3. NAME OF DECEASED (Type or Print) MARZE	a. (First) W.	b. (Middle) BLAIR	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) April 27, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 7, 1859	9. AGE (In years last birthday) 91	10. UNDER 1 YEAR Months 9 Days 20	11. UNDER 1 MIN. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret.)	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) Greenwich, N.Y.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Nelson Blair	13b. MOTHER'S MAIDEN NAME Mary Hurd	14. NAME OF HUSBAND OR WIFE Elizabeth
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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 xx	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Claude Dawkins, Chillicothe, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Crown Thrombosis</u>		10 minutes
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		30 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>cause of large bowel</u>		5 years	

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) m.	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 Apr. 1947, to Apr. 1951, that I last saw the deceased alive on Apr. 1951, and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE Charles M. Green (Degree or title) M.D.	23b. ADDRESS Chillicothe, Mo.	23c. DATE SIGNED 28 Apr. 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/30/51	24c. NAME OF CEMETERY OR CREMATORY Catholic	24d. LOCATION (City, town, or county) (State) Chillicothe, Mo.
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DATE REC'D BY LOCAL REG. 4/28/51	REGISTRAR'S SIGNATURE Francis B. Neill	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donald H. ... Chillicothe, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1592

0592



• 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 *Ronald Jordan*.....

Signed.....
Student Embalmer

Licensed Embalmer No. 491.....

P. O. Address *Phillips, 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.