

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23605**

FILED **JUN 30 1953**

BIRTH NO. _____ REG. DIST. NO. **339** PRIMARY REG. DIST. NO. **6150** Registrar's No. **9**

1030

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

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) Rural - New Lisbon Twp		c. CITY (If outside corporate limits, write RURAL and give township) Rural - New Lisbon Twp	
c. LENGTH OF STAY (If this place) 1 day		d. STREET ADDRESS (If rural, give location) 1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Logan	c. (Last) Blond	4. DATE OF DEATH (Month) (Day) (Year) June 20, 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov 13, 1892	9. AGE (years) (Months) (Days) (Hours) (Min.) 60 7 7
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer	11. BIRTHPLACE (State or foreign country) Stoddard County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Not known	13b. MOTHER'S MAIDEN NAME Mary Proffer	14. NAME OF HUSBAND OR WIFE Mattie Blond
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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. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Harlan Poque	ADDRESS Emporia, Kansas
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nipulated pneumonia		INTERVAL BETWEEN ONSET AND DEATH 13-24 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage		
	DUE TO (c) Senility		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	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 **5 Sept, 1949**, to **20 June, 1953**, that I last saw the deceased alive on **20 June, 1953**, and that death occurred at **1:50 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE D. W. Merrill D.O.	(Degree or title)	23b. ADDRESS Advance, Mo.	23c. DATE SIGNED 25 June 53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE June 23, 1953	24c. NAME OF CEMETERY OR CREMATORY Lock Point Cemetery, Surrency, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 6/26/53	REGISTRAR'S SIGNATURE Pearl Reed	490	25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Neespa-Advance, Mo.	ADDRESS
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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 William H. Mery

Licensed Embalmer No. 4640

P. O. Address Advance, Ind

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.