

FILED OCT 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34942**

BIRTH NO. _____ REG. DIST. NO. **294** PRIMARY REG. DIST. NO. **3056** Registrar's No. **234**

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

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) Moberly		c. LENGTH OF STAY (In this place) 10 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wabash Employes' Hospital		c. CITY (If outside corporate limits, write RURAL and give township) Moberly	
3. NAME OF DECEASED a. (First) EMMETT b. (Middle) G. c. (Last) BLOOM		4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 19, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pass Conductor (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (In years) (Month) (Day) (Hours) (Mins.) 86
11. BIRTHPLACE (City and State or Foreign Country) Ind.		12. CITIZEN OF WHAT COUNTRY? Ind.	
13a. FATHER'S NAME Phillip Bloom		13b. MOTHER'S MAIDEN NAME No Data	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME A. T. Bloom, Moberly, Mo	
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) Heart Failure (expired in sleep.) ANTECEDENT CAUSES DUE TO (b) Renal Insufficiency, chronic DUE TO (c) Far Advanced Generalized Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION 4500	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Oct. 11, 1954 , to Oct. 21, 1954 , that I last saw the deceased alive on Oct. 21, 1954 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.	
23. SIGNATURE W. Anderson M.D.		23b. ADDRESS 415 Woodland	
23c. DATE SIGNED 10/21/54		24. LOCATION (City, town, or county) (State) Moberly, Mo.	
24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-23-54	
24c. NAME OF CEMETERY OR CREMATORY Oakland		25. FUNERAL DIRECTOR'S SIGNATURE Mahan and Son, Moberly, Mo.	
DATE REC'D BY LOCAL REG. 10/23/54		REGISTRAR'S SIGNATURE Seal	

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Frank D. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.