

FILED DEC 14 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39930

BIRTH NO. _____		REG. DIST. NO. <u>360</u>		PRIMARY REG. DIST. NO. <u>6225</u>		Registrar's No. <u>167</u>			
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wash Township</u>		c. LENGTH OF STAY (in this place) <u>6m 9d.</u>		c. CITY OR TOWN <u>Miller</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>State Hosp 3 Nevada Mo.</u>				F. STREET ADDRESS (If rural, give location) <u>RFD 2</u> <u>0350</u> <u>7</u>					
3. NAME OF DECEASED (Type or Print) <u>GEORGE - E. - BLALOCK.</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <u>Dec 10, 1954.</u>		(Month)		(Day)		(Year)			
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 29, 1873</u>			
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>11</u>		IF UNDER 4 HRS. Hours <u>-</u> Min. <u>-</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>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Wm Blalock</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Haunsinger</u>			14. NAME OF HUSBAND OR WIFE <u>Dora Belle Bryant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hosp 3 Nevada Mo</u> ADDRESS <u>no</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, asthenia, 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>Chronic Myocarditis</u>				ANTECEDENT CAUSES					
DUE TO (b) <u>arteriosclerosis</u>				DUE TO (c) <u>senility</u>					
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Psychosis</u>					
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? <u>4221</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		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 <u>June 1</u> , 1954, to <u>Dec 10</u> , 1954, that I last saw the deceased alive on <u>Dec 9</u> , 1954, and that death occurred at <u>7:30A.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Paul L. Barone M.D.</u>				23b. ADDRESS <u>State Hosp 3 Nevada Mo</u>		23c. DATE SIGNED <u>Dec 10/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>12-10-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Stahl</u>		24d. LOCATION (City, town, or county) (State) <u>S.W. Miller Mo.</u>			
DATE REC'D BY LOCAL REG. <u>12-10-54</u>		REGISTRAR'S SIGNATURE <u>Anna E. Ferris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Merino Simon</u>		ADDRESS <u>Miller Mo</u>			

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

(Licensed Emballer's Statement on Reverse Side)

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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.....  
Signature of Student Embalmer

Signed..... *S. R. Leman*

Licensed Embalmer No. 329

P. O. Address *Miller*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.