

FILED APR 8 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

10676

BIRTH NO.		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>570</u>			
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>					
b. CITY OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY OR TOWN <u>Sikeston</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>616 N. Ranney Ave.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ben</u>			b. (Middle) <u>Frank</u>		c. (Last) <u>Blanton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 23 1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-9-1880</u>		9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 4 HRS. Hours	IF UNDER 4 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Howard Co., Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Blanton</u>			13b. MOTHER'S MAIDEN NAME <u>Harriett Young</u>			14. NAME OF HUSBAND OR WIFE <u>Edith Wheeland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. C. L. Blanton, Sikeston, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Insufficiency, Acute</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.  DUE TO (c)								
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. Pulmonary Edema</u> <u>2. Jaundice</u> <u>3. Previous Myocardial Infarction</u>							<u>4 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>							20. AUTOPSY? 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 <u>3-22</u> , 19 <u>55</u> , to <u>3-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-23</u> , 19 <u>55</u> and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Charles B. Smith M.D.</u>				23b. ADDRESS <u>Sikeston, Missouri</u>			23c. DATE SIGNED <u>3-29-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3-26-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston MO</u>				
DATE REC'D BY LOCAL REG. <u>4-1-55</u>		REGISTRAR'S SIGNATURE <u>Miss Ella Hunter</u> 429			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welch Funeral Home Sikeston Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED APR 4 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 455-81

MAY 18 1955

APR 22 1955

JUN 12 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision:.

Student.....  
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 340

P. O. Address Stanton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.