

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013730

STATE FILE NUMBER

FILED APR 16 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 201

300
1-57

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>CHESTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOPLIN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GALENA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FREEMAN Hosp.</u>		Length of stay in lb <u>12 days</u>	815 ^d 8 STREET ADDRESS (If outside, give location) <u>1200 Keller</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CLEMA</u> Middle <u>BLICK</u> Last <u>BLICK</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1959</u>			
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1876</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>GRANBY, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Shaw</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH Tempa Welch</u>	14. NAME OF HUSBAND OR WIFE <u>Scott BLICK</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Otis Blick</u>	Address <u>Galena Kansas</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction, left anterior</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-31-59</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pneumonia, right lower chest</u>	<u>4-7-59</u>
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, 1 1/2 years.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>Sept. 20, 1957</u> to <u>April 12, 1959</u> and last saw her ^{her} him alive on <u>April 12, 1959</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>607 Frisco Bldg, Joplin, Mo.</u>	22c. DATE SIGNED <u>4-13-1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Galena Kansas</u>
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24. FUNERAL DIRECTOR <u>Ray P. Desplatt</u> ADDRESS <u>Galena Kan</u>	25. DATE RECD. BY LOCAL REG. <u>4-13-1959</u>	26. REGISTRAR'S SIGNATURE <u>Nooe Merriam</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

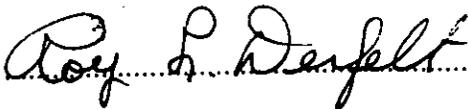
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No.

P. O. Address

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.