

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-138805

STATE FILE NUMBER

300
1-57

Health,
Welfare
Public
Service

FILED APR 28 1959 Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Webb City</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webb City 04920</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>IO18 W 1st Street</u>		Length of stay in lb <u>2 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>IO18 W 1st Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>E</u> Last <u>Bly</u>			4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1959</u>
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>March 25 1887</u>
9. AGE (In years last birthday) <u>72</u>		10. F UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
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>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Union, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>William Allen</u> 13b. MOTHER'S MAIDEN NAME <u>Lillie Hansen</u> 14. NAME OF HUSBAND OR WIFE <u>Frank Bly (Deceased)</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. <u>None</u>	17. INFORMANT Address <u>Myrtle Carrillo Chicago, Ill.</u>
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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Atherosclerosis.</u> DUE TO (c) <u>Atherosclerotic Heart Disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>unknown</u> <u>7 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour _____ 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	
21. I attended the deceased from <u>3-11-59</u> to <u>4-24-59</u> and last saw her alive on <u>4-24-59</u> Death occurred at <u>7:40 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wm. Wells-Lee D.O.</u>		22b. ADDRESS <u>924 N. Doughty Way, No. 2</u>	
22c. DATE SIGNED <u>4/24/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carterville Cemetery</u>
23d. LOCATION (City, town, or county) <u>Carterville, Mo</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Hedge-Lewis Funeral Home Webb City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-25-59</u>	26. REGISTRAR'S SIGNATURE <u>Ms. Madeline Switzer</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without.

All diseases in Part I must be causally related.

Wm. Wells-Lee-D.O.

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, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Richard G. Lewis*

Licensed Embalmer No. *11495*

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